Nel[illegible] Gorgas Reviews the Brown Report: Page 186
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Should There Be a Tenure Law?

November
VOLUME 71 NUMBER 5
1948

the Modern Hospital

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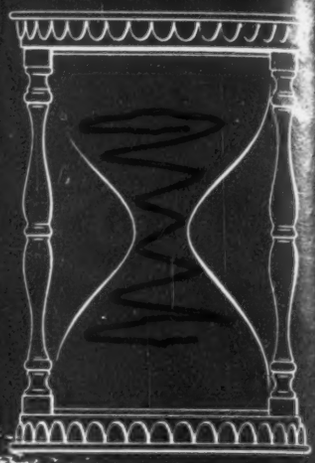

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In this issue:

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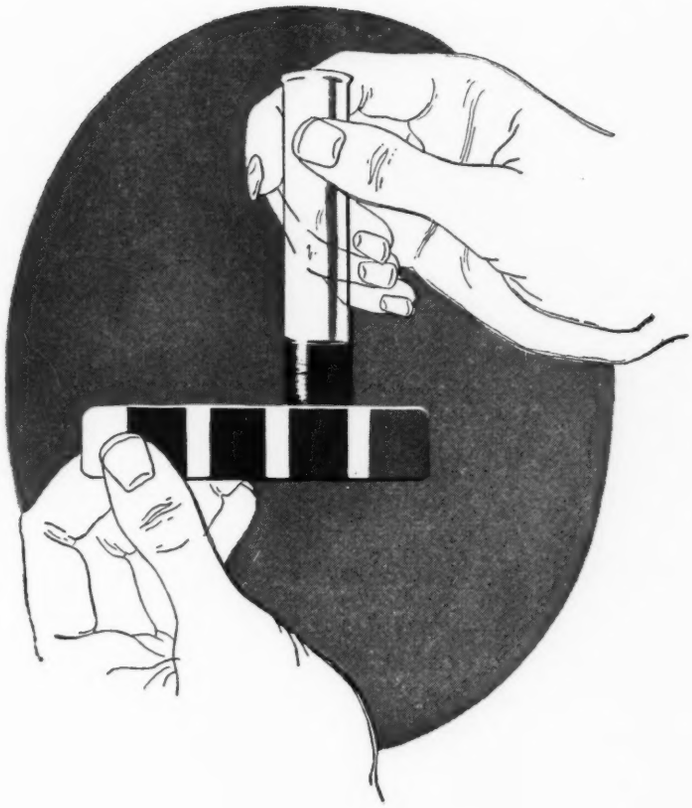

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AMONG THE AUTHORS

Dr. W. James Gardner is head of the department of neurosurgery at the Cleveland Clinic and professor of neurosurgery at the Bunts Institute there. He received his medical degree from the University of Pennsylvania in 1924. After an internship and residency in neurosurgery at the University of Pennsylvania Hospital, he became instructor in surgery at that institution. Dr. Gardner served in the United States Army in the first World War and with the Navy in World War II. He is the author of many articles dealing with neurosurgical problems and a member of many professional organizations.

Ruth M. Anderson, R.N., co-author with Dr. Gardner of the article in this issue describing their oscillating mattress, is assistant director of nursing at the Cleveland Clinic, a position she has held for the last two years. A native Clevelander, Miss Anderson was graduated from Mount Holyoke College in 1942 and received the master of nursing degree from the Frances Payne Bolton School of Nursing, Western Reserve University, in 1945. Miss Anderson served in the United States Naval Reserve during the war.

Daniel Paul Higgins is a member of the architectural firm of Eggers & Higgins, New York City. Among the architectural projects he has completed are the Triboro Hospital, Queens, New York City; the D.A.R.'s Constitution Hall in Washington; the National Gallery of Art and the Jefferson Memorial in Washington, and a number of educational buildings in New York City and elsewhere. Education and welfare of the growing child, as a matter of fact, has been a lifelong interest of Mr. Higgins, who has been a leader of the Catholic Youth Organization for many years and is now its president.

James G. Carr's interest in hospital administration, like that of many others among the younger group in the field, dates from his army service as a medical administrative officer. During the war he was administrator of a seventy-five-bed prisoner of war hospital in Tennessee, where he literally learned the hospital business from A to Z—having opened, operated and closed the hospital during his tour of duty there. A graduate of Northwestern University in the school of business administration, Mr. Carr is now personnel and finance officer of the University of Nebraska Hospital and College of Medicine at Omaha. He is also a trustee of the Nebraska Hospital Association and an instructor in hospital management at the university.

James E. Stuart is executive director of Hospital Care Corporation, southwestern Ohio's Blue Cross plan, with headquarters at Cincinnati. Mr. Stuart joined the Blue Cross organization as director on Jan. 1, 1942, shortly after it was established, and has guided its development into one of the country's largest and soundest voluntary health plans. He came into Blue Cross from the field of public welfare administration, having served previously as assistant director of Cincinnati's community chest and director of public welfare for Hamilton County. Before going to Cincinnati, he held welfare offices in Washington, D.C., and Westchester County, New York.

READER OPINION

Convention Digest

Sirs:

The best comment is to say that I read it through without laying it down. As president of a hospital board of trustees, I was naturally interested in the subject matter. As a newspaper editor, I was more interested in it as a splendid piece of journalism. It was a wonderful demonstration that a gathering like that can be reported in a manner that is both informing and readable.

Archie E. McCrea
Muskegon Chronicle
Muskegon, Mich.

Sirs:

It was a very pleasant surprise to receive the Digest almost before I got back from Atlantic City.... It is entertaining as well as informative, with its musical background.... It was sent to our board president.

Jessie P. Allen
Kingston Hospital
Kingston, N.Y.

Sirs:

On this Monday morning I wonder if you can imagine my surprise at receiving in the mail a pamphlet containing all the news of the Atlantic City meeting. Congratulations! It certainly was a scoop for MODERN HOSPITAL.

L. C. Vonder Heidt
West Suburban Hospital
Oak Park, Ill.

Sirs:

Once again the Digest reached my desk faster than the post-election issue of *Time*. I don't know how you do it! You do not sacrifice completeness for haste, since the entire convention seemed covered.

Graham F. Stevens
Geisinger Memorial Hospital
Danville, Pa.

Sirs:

Thanks to you, I attended the meeting without spending a dime; I have a feeling I should send you a check for my anticipated expenses. You left your mittens at home and handled the whole affair in a fine, barehanded way. I urge that in the future you follow this same line, because it is a very excellent demonstration of common sense reporting.

John R. Smiley
St. Luke's Hospital
Kansas City, Mo.

Sirs:

Thanks! The need for note-taking at the convention is eliminated. Rereading the points recalls to mind ideas that were aroused during the meetings and later forgotten.

M. Langehaug
St. Luke's Hospital
Fargo, N.D.

Sirs:

I would like to tell you how good I think the Digest is. Your interesting and brilliant reporting job helped to give our board a very graphic and vivid picture of the occasion. If this is the type of reporting job you are doing, I am remiss in not being a subscriber... please enter my subscription....

Harold Cabot
President
Emerson Hospital
Concord, Mass.

Sirs:

I whipped through the Digest word for word. You must literally have worked around the clock to have done such a good job. The people in the pictures even look like human beings.

Emily C. Deming
Butterworth Hospital
Grand Rapids, Mich.

Sirs:

Thanks for a prompt and clever presentation of convention facts. Your report made me feel I had a part in the convention.

Celeste K. Kemler
Valley View Hospital
Ada, Okla.

Sirs:

Mac, on the cover, looks like Jeremiah. The style throughout is unmistakable.

Joseph G. Norby
Columbia Hospital
Milwaukee

Sirs:

It is good of you to supply us so promptly with an interesting and in-

formative summary of the meeting—a genuine service to those of us who were not in attendance.

Sister Mary Ruth
Wheeling Hospital
Wheeling, W. Va.

Sirs:

I read with great interest and enjoyment your breezy account of the convention. It was good—I do not feel so badly now about not being able to attend.

Daniel M. Brown
Lodi Memorial Hospital
Lodi, Calif.

Sirs:

My compliments on the speed and contents of the Digest which I found on my desk... almost before the convention had cooled off!

W. Dayton Shields
Asbury Hospital
Minneapolis

Sirs:

I got so many chuckles that I had to read the whole thing aloud to my wife.

Donald M. Rosenberger
Hamot Hospital
Erie, Pa.

Sirs:

You certainly scooped everybody in sight with your Convention Digest.... The writing had a lot of pep and sparkle. For those of us who had to sit on the sidelines it was a most interesting review.

Susan S. Jenkins
Blue Cross-and Blue Shield
Kansas City, Mo.

A merry heart doeth good like a medicine.—ED.

Education of Administrators

Sirs:

The editorial in the July MODERN HOSPITAL, "Education of Administrators," has interested me a great deal. My assumption is that the "recent survey among hospital administration students" which revealed a "materialistic approach to the field" was the survey conducted by me earlier this year, which formed the basis for a short presentation at one of the Tri-State sections in Chicago in May. If I am in error in this assumption, I will appreciate having the name and address of the person conducting the survey to which reference is made.

That students take a materialistic approach to the field is a conclusion with which I do not especially take issue, but I take exception to the fact that this point of view is ascribed by your editorial writer to the results of the student survey.

Nor do I take particular exception to the moral drawn in the editorial, which I quote below, other than to state it is my conviction that the statement applies less to the hospital educators than to the leaders in the field, if they are not one and the same:

"Unless hospital educators and leaders enlarge their technical concept of the educational function, it seems likely that the students who are tomorrow's leaders may look upon the hospital more as a vehicle for their personal ambitions than as an organization of human beings devoted to the care of their fellow men."

However, this moral seems to stem from the sentence in the editorial directly preceding it, and to this I feel obligated to disagree, even object:

"If the student survey may be accepted as credible, it is evidence that the hospital courses are emphasizing technic at the expense of philosophy, an error that is characteristic of our time."

In order to point out to you clearly that such conclusions cannot in fairness be based on this survey, it should be

in order to review briefly the original manuscript presenting this survey, that we may see from what statements these conclusions are drawn by your editorial writer; it is my opinion that he should not have used this survey as the basis for the opinions expressed.

The original study was summarized in three parts, the second of which was titled, "What Does the Individual Expect of the Training Program?" and is quoted here for the record:

"Reasons for Interest in University Training in Hospital Administration: In quizzing my respondents for information to arrive at some conclusions on this topic, the following questions were asked: (a) Why did you enroll in the program in hospital administration? What was your motivation or inspiration? (b) What were your expectations of the program? (c) Why select university training rather than apprentice? Of course, twenty-nine different responses were received.

"There are a few conclusions which can be derived from the replies, however: Nine of the twenty-nine are affiliated in administrative capacity with hospitals now, either on leaves of absence, as active administrators taking the course, or as men who have been selected by hospital boards to manage hospitals planned or under construction, and who have come to the university for the best training available.

"About one in three had his interest stimulated as a result of military experience and exposure to hospital administrative work. Seven of the twenty-nine were interested in the humanitarian and service aspects; this proportion could, of course, be greater if those included in points mentioned previously were similarly analyzed. Several interrupted promising careers in other fields because of the challenging aspects of hospital administration. The time allotted will not permit further elaboration of the reasons for interest in hospital administration.

"With reference to the questions on expectations of the program, again a wide variety of responses was received: Those already in the hospital field expressed the need for a better background of demonstrated and practical theoretical training. Those coming to the program from other fields of endeavor emphasized the need for background in the specialized field of hospital administration which would best supplement the practical experience already obtained in other activities. And, too, quite a few of us candidly admitted that the prestige of university training, especially with the increasing emphasis on this aspect of preparation, will be no handicap in our chosen field of specialization."

It is important to note here that the phrasing of the survey was such that the student's initial "reasons for interest" are explored, not his current ideas on the subject after having been exposed several months to the philosophy of the program.

Consequently we cannot justify the editorial statement which read: "If the student survey is credible, it is evidence that the hospital courses are emphasizing technic at the expense of philosophy . . ." since, as noted above, the survey made no attempt to probe a student's philosophy after exposure to the training.

Actually, there are only a few conclusions which we can justifiably draw from this survey, and they are not nearly so sweeping as those suggested in your editorial: (1) About one-third of those replying came to the university already affiliated with a hospital; naturally, they hoped to be better administrators, but the survey did not attempt to ascribe a reason for this very human and commendable desire to perform their chosen occupations better. Who can then assume that such desire is purely materialistic? The survey did not attempt to show this. (2) About one in three discovered while in the armed services during the recent war that they liked hospital work. Can we in fairness say whether or not their motives in coming to the university were materialistic? The survey made no attempt to provide this answer. (3) About one in four was attracted to the field primarily by the humanitarian aspects of the field; but this does not preclude or attempt to include those under points (1) and (2) above, who together represented the majority of the sample (about 65 per cent). (4) The statement was made in the quoted portion of the survey that "quite a few of us candidly admitted the prestige of university training . . . will be no handicap." This is true regardless of motive, whether humanitarian or materialistic. Even humanitarian aims may be more readily realized if we are properly equipped for the undertaking. I note, too, that the field of care of the sick seems acutely aware of the value of degrees of varying degree, whether earned or honorary.

Editorially you stated, "many students spoke frankly of the prestige or label value of a degree, as opposed to the actual content of the training." I be-

(*Continued on Page* 130.)

SMALL HOSPITAL QUESTIONS

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Don't Alienate the Public

Question: A number of our board members seem to feel that as long as we have a bed shortage and since we keep running in the red, we ought to restrict our admissions to local people and not admit persons from outlying towns. An alternative suggestion is that we ought to charge the out-of-town people more. What good arguments are there to combat this type of thinking?—E.V., N.J.

ANSWER: The attitude expressed by a few of your board members, with particular reference to higher rates for out-of-town residents, is contrary to the thinking of all informed hospital people. Most boards are anxious to attract patients from an ever widening area, in keeping with the wishes of staff doctors, chamber of commerce officials, and business men in general in any trade center town.

It goes without saying that the hospital or hospitals in any one town must first of all analyze their losses on indigent patients who are the responsibility of the state, city, county or township welfare officers. If the hospitals can get together and, in the event that friendly persuasion fails, can legally force welfare offices to pay, they can obtain full costs for indigents.

If, in practice, you finally succeed in obtaining no less than cost from, or on behalf of, any type of patient, and receive more than cost payments for semi-private and private patients, then the hospital should have plenty of revenue to warrant going into an expansion program so that it can serve all patients, no matter from whence they come.

Three Groups Needed

Question: The report of the committee on nursing problems of the American Medical Association practically ignores the auxiliary worker group—the nurse's aides with from four to six weeks' training. Do you feel that the division into two main groups (graduate and practical nurses) is sufficient, or do you favor a three-group nursing organization (graduate, practical and aides) for most hospitals?—C.A.B., Ida.

ANSWER: Not all authorities agree entirely with the U.S. Department of Labor estimates that 550,000 nurses will be required by 1960 and that this will require the graduation of 50,000 nurses per year from 1951 to 1960. The latest statistics show that 65 per cent of those caring for patients now are R.N.'s, with only 35 per cent in the practical nurse and other auxiliary personnel category. Experience, common sense and economics demand that this ratio be modified, if not actually reversed; it is difficult to believe that we can find employment at proper wage levels for 550,000 R.N.'s.

I agree with that part of the A.M.A. report which says that the clinical nurse (comparable to the present day graduate general duty nurse) can and should be trained in two years rather than the present three-year program. I am also in complete agreement with the committee's statement emphasizing the value of the trained practical nurse.

However, nowhere in the report is there any reference or any clear-cut recommendations on the subject of nurse's aides (trained on the job) or clerks for nursing units. Studies have shown that the combined clerical duties performed by nurses on any one average nursing unit just about equal the time of a clerk. Here, again, experience has proved the practicability of using clerks.—E. W. JONES.

Costs in Children's Hospital

Question: We are interested in obtaining the most recent figures available on per diem costs for children's hospitals. Our patients are physically handicapped children under 21 years of age. For comparative purposes, we should like to have any figures or statistics which you might have on national or regional average per diem costs for institutions offering similar services.—M.L., Ga.

ANSWER: In general, hospital facilities for handicapped children average about 70 per cent of the cost of an acute general hospital bed. This will, of course, vary with the many factors involved, most important being the type of treatment given. The length of stay is also important as it affects the per patient day cost. Our cost for treatment of crippled children is $12.73 per day. This includes all expenses relative to the treatment of the patient other than the salaries of the attending doctors.—RAY E. BROWN.

Cumulative Sick Leave

Question: Can it be assumed that all allowable sick leave will be used by the average employe each year?—M.W., Wash.

ANSWER: The concept of sick leave should be thoroughly understood. "Sick leave" is provided to protect the employe against loss of earnings as a result of illness and for no other reason. It is in no sense a form of vacation. For this reason, sick leave should be cumulative up to as much as six months in order to protect long-term employes from loss of income due to serious illness after many years of service without previous illness. The hospital should seriously question any employes who consistently utilize their annual sick leave.—WILLIAM J. DONNELLY.

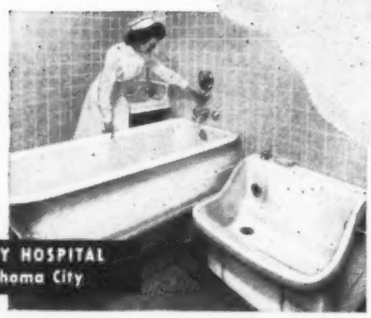
They Paid

Question: Our hospital is incurring financial losses in spite of rates that seem to be as high as we can reasonably charge. Further operating economies may be possible but could save only a few cents a day at best. Short of a fund raising campaign in the community, which we are advised would be hard to put over without a building program, do you have any suggestions for financial relief?—R.M., Minn.

ANSWER: Why should private and semiprivate self-pay patients and Blue Cross patients be expected to make up through their payments the deficits incurred in the hospital because of the low cost payments from city, county and state agencies for indigent patients, and for the losses incurred in operating outpatient department clinics?

An outstanding example of what can be done when hospital trustees will consider the problem intelligently and exhibit some courage is shown by what happened recently in one community in Michigan. The hospital in that city decided it was all through taking losses from government agencies. It billed the county welfare department of that area for welfare patients at the hospital's calculated cost per patient per day. When the welfare officials refused to pay, the hospital started legal action, with the result that it was paid at cost and will be so paid in the future.—E. W. JONES.

leading hospitals agree . . .



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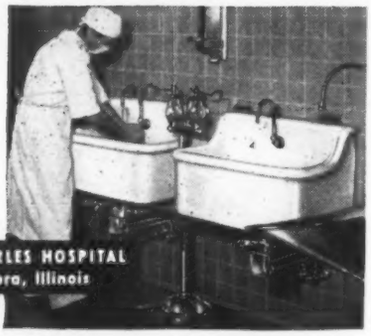

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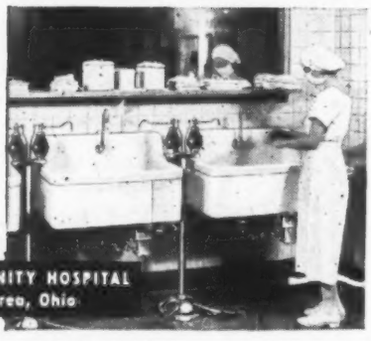

COMMUNITY HOSPITAL
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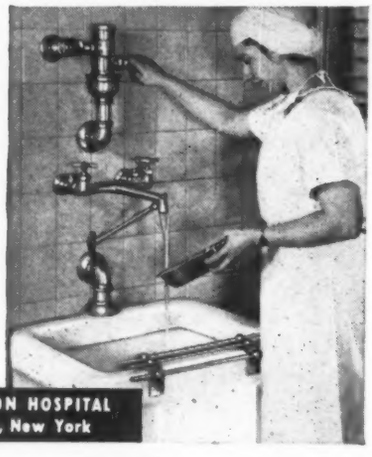
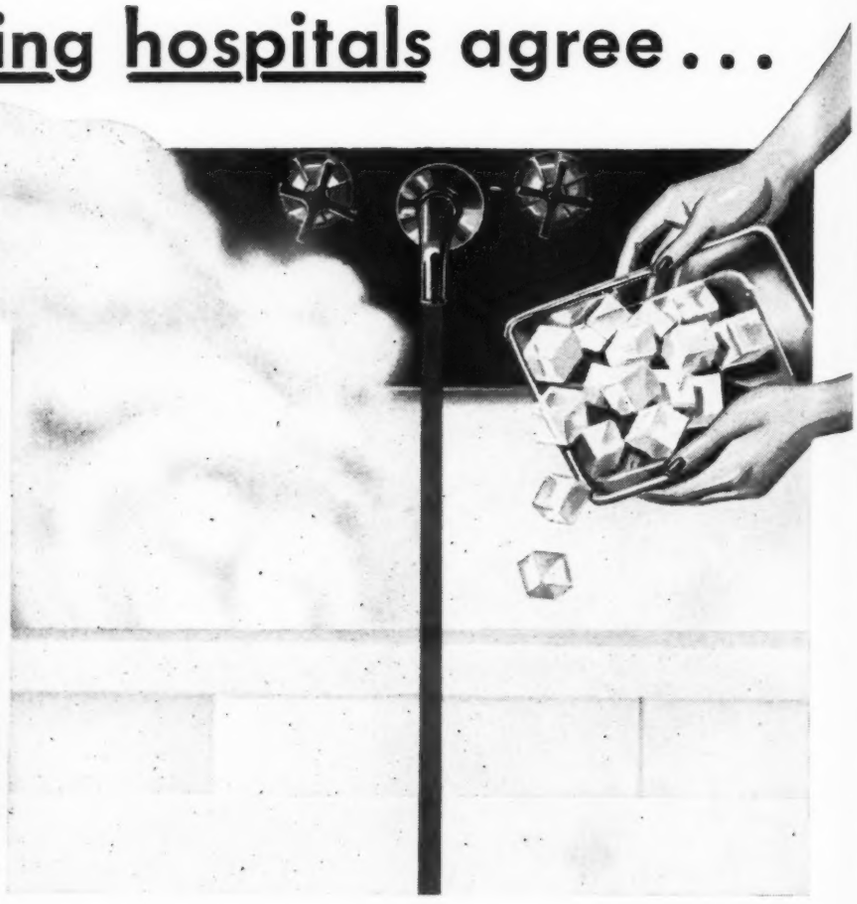


LEBANON HOSPITAL
Bronx, New York



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Looking Forward

The People Have Shouted

AS THIS issue goes to press the reelection of President Truman leaves the hospital and medical professions, among many other groups, wondering what the unexpected result will mean to them and feeling uncomfortably that whatever it is, it won't be good. Possibly the outstanding fact that emerges from the election is its revelation that authorities in nearly all business and professional fields have been wrong in their estimations of what the majority of people in the United States want.

Of course, the election enormously strengthens the hand of those who want a national health program, including compulsory hospitalization and medical care insurance. This legislation has been high on President Truman's list of objectives ever since he came into office; repeated affirmations of its desirability by the President and his principal advisers leave no doubt that it will be reintroduced promptly into the new Congress. With Democratic majorities in both Houses, its passage must be regarded as likely, if not assured. As a matter of fact, senators and congressmen opposing the legislation have said privately that it would have passed the 80th Congress if it had ever come to a vote, so great was the pressure in its favor from farm and labor groups.

Under the circumstances, plans for the nationwide Blue Cross-Blue Shield Health Service may prove to be too little too late, though certainly prompt completion and presentation of the contemplated program still offers the best available means of forestalling unfavorable action by Congress. Medical groups objecting to the proposed joint health service on the ground that it would give too much power to a board of directors including lay members may now support it because a lay board that is voluntary is better than a lay bureau that isn't. While it may have been advanced in all sincerity, the view that there is no need for such a national plan should have gone down the drain with Republican hopes.

The criticism that compulsory health insurance would create an unwieldy bureaucracy and deteriorate the quality of medical care is as valid today as it ever was. The view that it is wanted only by Communists and others hell-bent on regimenting everything in sight never did make any sense and should now be forgotten. The right course for medical and hospital groups to follow is the same today as it was before the election: Offer the best possible substitute for compulsory health insurance at the earliest possible moment, and combat faulty legislation on the basis of its faults.

If the people said anything November 2, they said that they want the government to run their lives to a greater extent than many of us think is good for them. If we can't keep this from happening by pointing out where it is wrong and why, we must turn to and help the government get the job done right.

Building and Brooding

IN ONE community where a hospital building program is under consideration, the hospital board of trustees, the doctors and, in fact, a sizable segment of the whole population are split down the middle on the question of whether or not to build the additional facilities now. "The need is now, not later," says the let's-build group, pointing to beds in corridors, waiting lists of patients and other evidence that the hospital is failing its responsibility to the community by not building right away.

But, "We haven't got the money to build at today's prices," the let's-wait people reply, emphasizing that the proposed addition would also increase the hospital's operating deficit—already hard enough to manage. "Besides," this group concludes darkly, "the time is coming when there will be plenty of empty beds."

It is likely that this same divisiveness exists in hundreds of communities today. In a few cases, the facts may indicate pretty clearly that one group is right and the other is wrong. When the need is plainly urgent and the funds are on hand or readily available, for example, construction certainly should not be held up by unreasonable, diehard conservatism or fear of what might happen at some vague, future date. On the other hand, there may be danger that the heady idea of expansion is sweeping another community into a building program not fully justified by demonstrable needs that can be met in no other way. Unhappily, too, opposing factions are not always pure in spirit: The happenstance of a close

social relationship between the chief surgeon and the contractor who wants to build the addition may give the need for beds an urgency that is more apparent than real, while an influential banker who wants to avoid getting clipped for a big donation to the building fund may readily envision economic obstacles that don't actually exist.

With some logic and some pressure on both sides, how can the administrator help find the right answer for his community? Obviously, no set of rules can be written that will apply in every case, but here are two warnings for the administrator:

Do not favor expansion yourself on the theory that a bigger hospital means a bigger job and a bigger salary for you. If the hospital goes broke getting bigger you'll probably be out of a job anyway.

Do not, if you can help it, play politics. If you make up your own mind on the basis of what is best for the community, both sides will respect you. If you play along with one or another group for any other reason, you are likely to end up making them both mad.

Gifts and Grafts

IN RECENT months there have been several reports to the effect that hospital administrators are accepting, or hinting that they would accept, some form of graft from manufacturers and distributors who want hospital business. "There have always been a few grafting administrators and buyers in the field," one manufacturer's representative said recently, "but it seems to us that this practice is growing."

What is graft? Cash bribes offered and accepted in consideration of purchase orders, and rebates or cutbacks of salesmen's commissions, are certainly graft, but it is doubtful that there is very much of this kind in the hospital field. When it comes to gifts presented and received without mention of specific purchases, but certainly in exchange for favors given or anticipated, it is harder to identify graft as such. This difficulty is a boon to easygoing consciences; many administrators who would piously refuse a bribe or cutback regularly accept elaborate gifts of merchandise—implicit bribes on the same moral plane as the cash handout.

Public utilities, railroads and other large industries often require purchasing department employes to list all the gifts they receive from suppliers, especially at Christmas time, and to return any that are judged to be more than token acknowledgments of friendly relations. In the common industrial practice, for example, the gift of a radio or an expensive pen and pencil set might classify as graft, while a box of fruit or a billfold would not.

The company that keeps a close check on gifts is probably not too concerned about their effect on the purchaser's moral fiber. Rather, management knows that the practice can get out of hand in a hurry and that everybody loses when it does. When suppliers compete with one another in the lavishness of their donations or entertainment instead of in the quality of their products, somebody is going to get gypped. In the hospital field, it is the patient who ultimately foots the bill.

Does It Take a Law?

IT WOULD not be possible or sensible to anticipate the results of the study which will be undertaken by the commission on hospital finance now being organized by an American Hospital Association committee. It seems unlikely, however, that the commission is going to discover any new sources of money. That being the case, its studies must necessarily be directed toward getting more money for hospitals out of existing sources, and possibly also toward getting more value out of the money hospitals already have. (This is assuming, of course, that the commission's investigations will reveal that the major money problem of hospitals is its lack. It seems a safe assumption.)

As a matter of fact, the commission would probably justify its existence and whatever time and money may be spent on its activities if it accomplished only one objective: to focus national attention on the necessity for putting public aid hospital care on a pay-as-you-go basis instead of the pay-what-you-want basis that prevails today. Most hospitals caring for indigents either are crippled financially by inadequate payments from the responsible public bodies or, and this may be worse in the long run, are making up the deficits incurred in the care of indigents by overcharging everybody else. This secret and involuntary tax on the sick is widely believed to be a simple gouge by people who pay hospital bills and don't know why they are so high.

Already some observers foresee that the commission study may ultimately result in a federal law providing grants to states for hospital aid, just as the Hospital Care Commission study shaped and speeded the federal law providing grants for hospital construction. Under any such law there would probably be some operating equivalent of Appendix A, setting the standards hospitals would have to meet to qualify for aid. While this feature would be despised by many as control or interference and an evil thing, it might at last provide the spur that is needed to make hospitals find out what their costs are and establish rates accordingly for all kinds of patients. This could be done without a law.

THE TASK OF THE ADMINISTRATOR

Is Ordering the Means to the End

ROBERT M. HUTCHINS
Chancellor, University of Chicago

THE longer an administrator administers, the more he is impressed by the peculiarities of his calling. The task of the administrator is to order means to ends. I shall first display the administrator at work with the means, and shall try to suggest the qualities that are required for the performance of his duties in regard to them, whether or not the end is clear, correct, or given. I shall then pass to the administrator at work with the end, the administrator who is seeking to define, clarify, or discover the aim of his institution. This is the highest function of the administrator. To perform it he needs all the qualities that are required for the disposition of means and, in addition, certain special, and very rare, abilities. The peculiarities of institutional administration relate both to the means and to the end. But the most difficult and most important problems are those which concern the end.

The minimum qualifications of an administrator in his dealings with the means are four. They are courage, fortitude, justice, and prudence or practical wisdom. I do not include patience, which, we are told, President Eliot came to look upon as the chief requirement of an administrator. For reasons which will appear later, I regard patience as a delusion and a snare and think that administrators have far too much of it rather than too little.

I do not include temperance, which in the case of the administrator would be the habit of refraining from making decisions that should be made by his subordinates. Nor do I include the theological virtues: faith, hope, and charity, though the administrator needs them more than most men. I omit them because they come through divine grace, and I am talking about what the administrator can accomplish by his own efforts. Since it is not within his power to obtain the theological virtues, I must leave him to work that he may deserve them and pray that he may receive them.

When I say that the administrator should have courage, fortitude, justice, and prudence, I am saying only that he should be a good man. If the administrator is to function at all, he must have prudence or practical wisdom, the habit of selecting the right means to the end. But the administrator's life reveals that, though the virtues may be separated for purposes of analysis, they are one in practice. The administrator cannot exercise prudence without courage, which is the habit of taking responsibility; fortitude, which is the habit of bearing the consequences, and justice, which is the habit of giving equal treatment to equals.

Habits are formed by action. The way to become a good administrator is to administer. But this is also the way to become a bad administrator; for vice is a habit, too. The minimum function of the administrator is to decide, and, since he has to make more decisions than most men, he has the chance to be either an especially good or an especially bad man.

But you will say that most of the administrators you have known have not been especially good or especially bad men. This is because there are three courses, rather than two, open to the man who holds an administrative position. He can practice the four virtues I have named, he can practice their opposites, or he can decline to make decisions. Since the third is by far the easiest course, it is the one most administrators follow. I have known university presidents who have performed the almost superhuman feat of making no recommendations to their boards of trustees. I knew one who publicly took the view that the trustees made the decisions; he did not.

The administrator is a man who decides upon the class of cases committed to his care. If he fails to de-

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cide, he may be an officeholder; he is not an administrator. The shifts and dodges and downright dishonesty to which administrators will resort in the effort to become officeholders are an element of low comedy in the high tragedy of institutional administration. Lord Acton has familiarized us with the notion that power corrupts. He might have added a word or two on the corruption wrought by the failure to exercise authority when it is your duty to exercise it.

Administration is unpleasant, as anything which requires the exercise of the virtues I have named must be. It is doubtful whether even these virtues can be exercised without divine aid. And the happiness which they give is not, I fear, a happiness in this life. The pressure upon an administrator to become an officeholder is enormous. But there is an easy way of avoiding these troubles, and that is not to take the job. No man of mature years who accepts an administrative position can claim that he did not know what his troubles would be. If there is such a man, he still has a way out; he can resign.

MARTYRDOM IS UNBECOMING

An air of martyrdom is unbecoming to the administrator. If he stays in office he has only himself to blame, and his failures will always be his own fault. They will result from his lack of moral stamina or mental capacity, or from his neglect of Bismarck's dictum that politics is the art of the possible. What is possible in any given situation depends to some extent on the material resources at the administrator's disposal, but far more on the abilities and spirit of his constituency. The administrator may make the wrong appraisal of his material resources or of the abilities and spirit of his constituency. He may overestimate his power to enlarge his material resources or to enhance the abilities and spirit of his constituency. If he is mistaken in any of these particulars, he has attempted the impossible and deserves to fail. If he fails, he should resign. He should not become an officeholder.

The administrator who is willing to be an administrator will find that the strain is chiefly upon his character, rather than his mind. Administration is a work of the mind, because it is ordering the means to the end, and the principle of order is the intellect. Prudence or practical wisdom is a

habit of the practical intellect. It involves knowledge of the available means and some rational notion of the effectiveness of the available means to promote the end in view. But such knowledge is not difficult to come by, and much of what passes for administrative knowledge is not knowledge at all. Knowledge is not information. The characteristic of knowledge is organization. There are few principles of administration, and they are simple and easy.

Prudence cannot be taught any more than courage, fortitude, or justice can be taught. You can be told what these things are. You can be shown examples of their exercise. But you develop courage, fortitude, and justice by practicing them, and so you develop prudence, too. I do not minimize the intellectual difficulties involved in reaching an important practical decision. I merely say that these difficulties are of such a nature that previous formal instruction will do little to assist in their solution, and that, compared with the strain on the character which the administration of the means carries with it, the strain on the mind is insignificant.

The strain on the character is very great. The administrator who is afraid of anybody or anything is lost. The administrator who cannot stand criticism, including slander and libel, is lost. The administrator who cannot give equal treatment to equals is lost. The administrator has all these ways to lose, and he has no way to win. Almost every decision an administrator makes is a decision against somebody. This is true even of decisions that look as though they were for somebody, like a decision to raise a man's salary. The administrator quickly learns that such a decision is really a decision not to raise the salaries of other men in the same department. The administrator must appeal for support to those whom he has alienated in the course of his duty. Some idea of his situation may be obtained by asking what sort of cooperation the President of the United States would get from Congress in his second term if he had had the duty, and had conscientiously performed it, of fixing the salary and rank of each member of that body for four years. If the administrator were a judge, he could expect the litigants to go away and leave him alone after he had reached his decision. As an administrator he must expect that those whom he has decided against will remain with him and view his labors as something less than inspired.

The natural course, then, is to become an officeholder. Your life will be much easier, and you may even become popular. To the administrator, the institution often seems like a gigantic conspiracy to turn him into an officeholder. The trustees have membership on the board because it is an honor. They are interested and pleased as long as the institution is prosperous—and peaceful. An administrator who administers is bound to cause trouble. Administrative decisions affect the lives, the fortunes, and even the sacred honor, of members of the staff. An administrator who wants the support of the staff will make as few decisions as he can. He will try to develop automatic rules covering all subjects to avoid the embarrassment which decisions on individual cases must cause him. In regard to new appointments he will seek to escape responsibility by appointing committees to advise him. He will resort to every undercover technic he can think of in order to have it appear that he did not make the decision, even when he did.

YEARN FOR THE DAYS OF COOLIDGE

There are few sins of omission in administration. Since the administrator's salary, prestige, and perquisities are high, he will be criticized under any conditions. But he will seldom be seriously disliked if he does nothing. People will say that he is a weak man and that he does not give the institution the leadership it should have. But secretly everybody yearns for the days of Coolidge, and academic communities, whatever their protestations to the contrary, really prefer anarchy to any form of government.

The temptation, of course, is to bury yourself in routine. There is so much routine—so many reports, so many meetings, so many signatures, so many people to see—all of some value to the institution, that you can conscien-

tiously take your salary and never administer at all. You can spend your entire time doing things which any $30-a-week clerk could do better and go home at night exhausted to report to your wife that you have had a hard day wrestling with institutional problems. The administrator who is determined to administer will find that the strain on his character is very great.

NO TIME TO THINK

The strain on his mind results not so much from the intellectual difficulty of his problems as from his inability to command the time, assuming the ability and the willingness, to think. The administrator who wants to administer will find that he cannot put in his time to the best advantage. On the one side are those things which are inevitable and urgent. On the other are those things which are important. The administrator should be devoting himself to those things which are important. But by definition he must devote himself to those which are inevitable and urgent. The question whether an assistant should have an increase in salary of $250 is not important, at least in an institution which has a deficit of one million dollars, which every well regulated university should have. A deficit of $1,000,250 should not differ significantly from one of $1,000,000. But this question must be settled while more important questions are postponed, because an offer from another institution must be accepted or declined, or because the budget must go to the trustees at a certain time. And it must be passed upon by the administrator ultimately responsible, because, though $250 is not important, the quality of the staff is.

The problem of time is insoluble. The administrator should never do anything he does not have to do, because the things he will have to do are so numerous that he cannot possibly have time to do them. He should never do today what he can put off till tomorrow. He should never do anything he can get anybody to do for him. He should have the largest number of good associates he can find; for they may be able to substitute for him. But he should be under no illusions here. The better his associates are, the more things they will think of for him to do.

Such thinking as the administrator can do will derive its value not so much from his extraordinary knowledge or intellectual capacity but from his locus in the institution. Like the architect, his view encompasses the whole and the interrelations of its parts. He is so placed that he can see the enterprise as a whole. He is likely to take a more detached view of the whole and its parts than any of the staff. Though he will not have much time to think, he can devote the time he has to thinking as objectively as possible about the whole. He has the knowledge, the position, and the duty to do so. The task of the administrator in ordering the means is to keep the institution up to its own standards. These standards are a reflection of the end. The commitments made by the administrator—and, whatever his virtues, he is bound to make some—gradually reduce his effectiveness and combine with gradual alienation of his constituency to bring his usefulness to a close. The administrator has many ways to lose, and no way to win.

The remedy is a term, at the end of which the institution can decide once more whether it wishes to be managed by an administrator or ornamented by an officeholder. Failing some provision for the automatic termination of his services, the administrator must be in a perpetual mood of resignation, by which I do not mean mournful acceptance of the universe. I mean he must be perpetually prepared to get out. This solution is not ideal. Nobody will tell the administrator he should resign; this would be impolite, and finding a successor is very difficult. The administrator is usually the last person to know he should resign. He can always rationalize his salary, prestige, and perquisites into a burning conviction of his necessity to the institution.

How does the administrator or his constituency know whether his decisions are right or wrong? Since he is deciding upon the means to an end, his decisions are right or wrong depending on whether they help or hinder the institution in its effort to achieve the end. Where the end is simple and clear, the appraisal of the administrator is easy. If the end of an army is victory, a general who wins is good. If the end of a business is profit, an executive who makes money is good. But the measure of the statesman can be taken only in the light of some defensible conception of the end of the state, and the measure of an institutional administrator only in the light of some rational view of the end of the institution.

The administrator cannot make the right decisions without some similar illumination. How can he decide on the means if he has no clear vision of the end? It is impossible for the administrator who understands the end to achieve it unless he has the character to select the right means, and impossible for him to select the right means unless he has the mind to understand the end.

The end of an institution gets lost as it matures. The enterprise goes on because it started and runs for the sake of running. If any other consideration than that of self-perpetuation is allowed to enter, it is usually that of prestige. Let us be famous for the sake of fame. We see a similar phenomenon in the case of states which have lost any conception of the end of political organization. They say, let us be powerful for the sake of power.

THEN THE DIFFICULTIES INCREASE

The task of the administrator in a new enterprise is relatively easy, for the purpose of the communal activity is clear and fresh in the minds of all the members of the community. Men are appointed to the staff because they are thought to be qualified for and interested in working toward the end. As the inevitable mistakes are made, as the vested interests harden, as the aim is changed to self-perpetuation, the difficulties of administration increase. The alteration takes place very rapidly. George Vincent, later president of the Rockefeller Foundation, who was a member of the first faculty of the University of Chicago, used to say that on the day the university opened, the faculty and students gathered in front of Cobb Hall and sang "Old Varsity" before the paint was dry.

If the end of the institution has got lost, if the institution has congealed, if it suffers from the disease of aimlessness, then all the administrator's moral difficulties are intensified, and his mind undergoes serious strain.

Now, in addition to summoning up the character necessary to select the right means, he must try to command the intelligence to discover the end. He must become a philosopher.

Men who possess and practice the virtues are rare enough. Good men who are also good philosophers are rarer still. Good men who are good philosophers and who are willing to run the extraordinary occupational hazards, moral and mental, of institutional administration are a race which appears to be extinct. The academic administrators of America remind one of the French revolutionist who said, "The mob is in the street. I must find out where they are going, for I am their leader."

FIRST PRINCIPLES ARE TROUBLESOME

As it is easy and tempting to become an officeholder rather than an administrator, so it is easy and tempting not to think about the end. As everybody in the institution prefers an officeholder to an administrator, so everybody in the institution prefers not to be reminded that the institution has, or should have, a purpose. The worst kind of troublemaker is the man who insists upon asking about first principles, and the first principle of any activity is the end. The last question that will be raised about the prospective administrator is whether he has any ideas. If it appears that he has, he is unlikely to be appointed, for he will rightly be regarded as a dangerous man. The situation is much the same as that in American politics: the men who are needed most cannot be chosen; the qualifications to do the job disqualify the candidate for the post.

Yet somebody in the institution must think about the end; for otherwise the institution will get lost or fall to pieces. The administrator must accept a special responsibility for discovery, clarification, definition, and proclamation of the end. But he does not own the institution. The administrator's responsibility is to get others to join him in the search for the end and to try to lead all his constituency to see and accept it when it has been found. He must conceive of himself as presiding over a continuous discussion of the aim and destiny of the institution. He must insist upon this discussion, and he must see to it that it never flags.

The difficulty is that the aim and destiny of any institution are not discovered by instinct or tradition; they must be arrived at by creative thought. For this, the administrator has neither the time, the atmosphere, nor the education which it demands.

The end is the most important matter the administrator can deal with but its consideration can always be postponed; there is never any time for it. Though the administrator shares his lack of education with his contemporaries, associates, and fellow-citizens, they may be able to do something about their inadequacy in their leisure hours. The administrator's leisure hours are few, his administrative problems follow him and plague his dreams, and his intellectual condition at the end of the day's work is such that he is barely able to cope with a detective story.

Yet Plato's answer to the question, What kind of administrators do states —and universities—require? is valid for us today, after almost twenty-five hundred years. He said, "Unless either philosophers become kings or those whom we now call our kings and rulers take to the pursuit of philosophy seriously and adequately, and there is a conjunction of these two things, political power and philosophic intelligence, there can be no cessation of troubles for our states, nor, I fancy, for the human race either."

Plato also tells us what kind of education is needed to produce the administrator we are seeking. Until the age of thirty-five, the candidate is to devote himself to his education, spending the last five years in the most profound metaphysical studies. Then for fifteen years he is to acquire practical experience in offices which Plato describes as those suitable to youth. The object is, of course, to develop the habit of practical wisdom, but even more to develop the moral virtues. In Plato's words, "And in these offices, too, they are to be tested to see whether they will remain steadfast under diverse solicitations or whether they will flinch and swerve."

At the age of fifty, those candidates who have survived all tests and shown themselves the best in every task and every form of knowledge are ready to become administrators. But each will serve only for a limited term. The philosopher kings alternate between periods of philosophical study and administration, with the longer periods devoted to philosophy. When the turn comes for each, they toil in the service of the state, holding office for the city's sake, regarding the task not as a fine thing but as a necessity. As a reward for these sacrifices they depart eventually for the Islands of the Blest, and the state establishes public memorials and religious rites in their honor as though they were divinities, or at least divine and god-like men.

Plato was writing a utopia. Utopias are the products of desperate situations. They are constructed when everybody sees that nothing can be done, except perhaps to indicate the ideals toward which future generations should strive. We look to Plato not for the specifications of a practical program to be taken over intact, but for guidance in the formation by our own efforts of a practical program for our own day.

The essential points are that the administrator should not want to administer, but should be forced to do so for the public good; that he should have a long period of education, culminating in profound speculative study; that he should undergo a great variety of practical experience to form his character and develop the habit of practical wisdom; and he should serve for a limited term, after which he should resume his studies, if he expects at some later time to have another. This is the kind of scheme which is called for if the administrator is to have the moral and intellectual qualities which the times demand.

THE VISION OF THE END

As the minimum function of the administrator is ordering the means, so his highest function is discovering and clarifying and holding before his institution the vision of the end. As the qualifications for the administrator's minimum function are courage, fortitude, justice, and prudence, so the qualification for his highest function is philosophical wisdom. At this epoch in history we can demand nothing less of the administrator than this combination of practical and philosophical wisdom, with the moral qualities necessary to sustain it.

The reward of the administrator may not be public memorials, religious rites, and a pleasant journey to the Islands of the Blest. For these things he should care not at all. His satisfaction will come, even if he fails, from having seen and attempted one of the most difficult works of the mind and one of the most challenging human tasks.

The V. A. Provides:

A Check List for Hospital-Community Relations

ON ALL sides, there is evidence of increasing awareness on the part of hospital people that their institutions cannot be operated successfully as islands unto themselves. Inter-hospital programs have assumed planning and building responsibilities in several of the larger cities. More and more, community hospitals are seeking to integrate their functions with those of neighboring agencies in health, education, social welfare and related fields. As Dr. Edwin Crosby aptly stated in a MODERN HOSPITAL article, "the public does not want a brick curtain between the people and the medical center to which they look for health."

In the large, metropolitan hospital, responsibility for these outward relationships is often recognized today by the employment of public relations experts, either as members of the hospital's administrative staff or as outside counsel. In the smaller community hospital this approach to the problem is often ruled out by budgetary restrictions. There remain, however, many activities and attitudes that will help the hospital meet its community obligations without adding a penny to operating costs.

In a statement released recently by Dr. Arden Freer, acting chief medical director, the Veterans Administration has given its hospital officers a practical guide to the improvement of community relations. It appeared under the title, "A Philosophy for Community Relations Planning in Veterans Administration Hospitals," and is reprinted here, in slightly condensed form, for its value to hospital administrators everywhere as a check list of activities that will help to assure the hospital of having its rightful place in the life and esteem of the community.—THE EDITORS.

A COMMUNITY'S respect for a hospital stems from the adequate medical care of its patients. Such care is adequate only if it provides sound professional and technical services supported and encouraged by competent management. It is not adequate unless delivered with an attitude of personal consideration and friendly respect for the patient. Every official, physician, nurse, attendant, technical specialist, clerk and every employe of the hospital, therefore, is responsible in some degree for good or bad public opinion of the hospital. The individual and collective performance of the staff will decide whether the patient is, as he should be, the hospital's best press agent.

The hospital's relationship to the patient is, by extension, a relationship to the community. In its full sense, adequate medical care does not begin at the hospital gate as he enters or end there as he leaves. The hospital is a part of the community and should so consider itself. The community should be encouraged to accept this view.

The hospital's employes are its representatives in the community. Their influence on relations with the community is second only to that of the patient. The employe is a resident of the community and consequently bears a responsibility not only to the hospital but also to his community for the care of patients. It is a responsibility not established, or limited, by regulations and procedure but only by the employe's own conception of his functions and obligations as a citizen.

In such a broad and encompassing view, it may be seen that the hospital's community relations are not, in primary emphasis, a system of press contacts revolving around the office of the manager. Publicity is but one element in the development of community relations. Rather, community relations are created by the total impact of the hospital's service upon public opinion. This view is in keeping with good medical practice, which is to treat patients requiring hospitalization and to treat outpatients entitled thereto who are not in need of hospitalization to the end that they may regain or maintain their places in the community. The objective, in short, is the conservation of health.

To achieve this goal the hospital must be articulate about what it is trying to do. The hospital should think of itself, and encourage the public to think of it, as a community authority on the problem of health. Through its patients and their relatives, through its officials and employes, the hospital should inform the public of its accomplishments and limitations.

It is not possible to establish a working relationship among hospital official, employe, patient and community by organization chart or by directive. Each member of the hospital staff, however, may ask himself and his associates a number of questions which will indicate both the spirit and the nature of activities necessary to enhance community relations.

What effort does the hospital make to indoctrinate both patients and employes in its objectives?

Do members of the staff give public talks and professional lectures on the various aspects of health and disease?

Are volunteer organizations encouraged to work in the hospital so that their special talents and abilities are fully used?

Are professional and lay groups encouraged to visit the hospital and use it as a meeting place for cooperative activities?

Do the leaders of the community turn to the hospital for advice and help on health matters?

Does the community's medical profession look to the hospital's medical staff for assistance in medical problems?

Do members of the professional staff of the hospital belong to local professional societies and committees?

Do employes of the hospital interest themselves in community activities?

Does the community accept hospital staff members socially?

Do the hospital chiefs seek to maintain friendly relations with the community's leaders?

Do responsible hospital officials give members of the press frank and courteous answers, with adequate explanation of background factors?

What effort is made to educate the family as to the nature of the patient's disability, to combat prejudice and to foster human understanding?

Does the hospital show its appreciation when community groups or individuals manifest an interest in good health and become active in its advancement?

As an example of a sound and workable approach to public relations, the following material has been abstracted from "Our Community Plan," a report addressed to its employes by the Veterans Administration Hospital in North Little Rock, Ark.:

The hospital is organized to function as a small, intramural community closely affiliated with a larger extramural community composed of the surrounding cities and states.

From their first day at the hospital all patients and personnel are indoctrinated with the ideal of living and working in a community where each group of persons is bound to other groups by common purpose.

Each patient is allowed every privilege he is capable of handling.

To maintain the community spirit among the hospital employes, coordinating committees work for cooperation between various sections and units as adjuncts of the hospital staff.

The press and radio may come into the hospital at will and are invited to the hospital when prominent visitors appear, a new program is introduced, or a new technic is developed.

Speakers are furnished to local clubs, civic organizations, professional societies, religious groups and the like. On National Hospital Day these groups are asked to permit hospital representatives to speak.

Contact is made with the various business men and industries through the vocational rehabilitation service, and community leaders are brought to the hospital to speak to the patients.

Consultants have been picked from the ranks of the leading practicing physicians and from the staff of the local medical school, and a plan of close cooperation and mutual support has been worked out.

The hospital takes part in the activities of the local medical, nursing and hospital associations and encourages staff members to do so.

By all these means and through editorials, press releases, speeches and other publicity, the public is informed of the problem of the hospital patient, the requirements of his proper care and treatment, and the objective of the community plan.

The Purchasing Department Has a Public Relations Program, Too

BY THE purchasing department's "public relations program" is meant, of course, contacts with sales representatives. I hope that some day we will be in a complete buyer's market. Deliveries are showing a substantial improvement as the backlog of orders decreases; additional salesmen are now in the field. In other words, the progressive companies are of necessity returning to selling and not just taking orders. The buyer will again be able to weed out inferior products. The buyer will again say "no."

That "No" is our public relations problem. We must be courteous; many a salesman was helpful during trying times. Don't just cut them off now with a curt "no." Many items will remain in the "hard to get" class for a long time to come.

1. Remember that keeping a sales representative waiting does not enhance your own reputation. Remember, too, that your salesman is an advertising agent of your hospital in all parts of the country.

Insofar as possible I try to have a certain time allotted to each salesman and when I cannot see him it is a matter of courtesy on my part to call him and postpone our meeting.

2. Observation of your salesmen will soon give you an opportunity to distinguish between those who have something important to offer and those who are just marking time and "shooting the breeze." Salesmen can often be of great assistance and we have all taken advantage of special sales offers.

3. Remember the salesman's problems are similar to yours; his time is valuable. If you are not going to buy let him know. He'll take the hint, I hope.

4. A good policy to follow is to send all purchase orders directly to the vendor and not give them to the salesman.

5. Most of us had our welcome mats out for salesmen during the war; is there any reason why a change should be made now?

6. Summing up, common sense, fair play, courtesy, firmness and good judgment remain the chief assets of a good purchasing agent's public relation program.—G. R. SCHREIBER, *Michael Reese Hospital, Chicago.*

ARCHITECT'S RENDERING OF THE VETERANS ADMINISTRATION HOSPITAL, ALBANY, N.Y.

"X" IS A KNOWN QUANTITY IN HOSPITAL DESIGN

DANIEL PAUL HIGGINS

Eggers and Higgins
Architects
New York City

UNDER construction in Albany, N.Y., is a 1000 bed Veterans Administration hospital, costing about $18,000,000, that will probably prove as fascinating to management experts as it is to hospital administrators and architects. The product of group thinking by all concerned, the hospital's objective is to encompass the best in architecture with realistic administrative needs. While this is an ever present problem in hospital design, it is especially significant in this case because of its size and scope which are greater than those of most general hospitals.

The "X" pattern of the Albany hospital was determined upon because, unlike its algebraic meaning, it is definitely a known quantity. It permits the most efficient flow of materials and persons to and from the end product of the hospital, which, of course, is the patient's bed. It eliminates duplication of facilities and provides shortest distances of motion because its core permits the grouping in one central channel of all traffic needs.

Further, the cruciform pattern proved elastic and adjustable when subjected to the test of encompassing a multitude and variety of hospital services. When all facilities were finally set in place, the plans proved this to be the case. But that was not all. While the facilities within the hospital had to be linked with one another, they also had to be welded to the auxiliary service functions outside the building. These included such activities as delivery of foods, handling of laundry, disposal of waste, and operation of maintenance shops.

The services that feed into the hospital were placed in the adjacent utility, or service, building in such manner as to lead right into the floors where consonant activities within the hospital take place. How this was accomplished can best be visualized through an understanding of site conditions which, though difficult, were adapted to our objectives.

The hospital site is irregular, running about 1600 feet back from New Scotland Avenue, which is on the north. Holland Avenue runs along the west side, Myrtle Avenue, on the east. The Albany Hospital is across New Scotland Avenue from the site.

The service building is three stories high on the Myrtle Avenue side, from which the land slopes sharply upward. In fact, the hospital building is situated on the pinnacle of a site that slopes in all directions from that point. On the Holland Avenue side, the gully was 40 feet deep.

There are four roads leading into the site. The main entrance road opens on Holland Avenue. A second road, from New Scotland Avenue, leads directly to the emergency department, providing entrance over the roofs of the shops. This road can be used by ambulances. The third is a connecting road from Myrtle Avenue. A fourth road, also from Myrtle Avenue, leads to a yard on the same level as the shops and to the basement level of the hospital building where trucks can deliver directly to the food handling and storage areas on that floor, which includes the main kitchen.

It will be seen, as we explore the activities on the floors of the hospital building, that these service arrangements synchronize perfectly with facilities inside the hospital.

In order to accommodate 1000 bed patients and 100 outpatients a day, related facilities were placed within the main structure so that they could profit most by use of the central core of the "X." The building has ten main floors and a four-story tower.

FUNDAMENTAL PRINCIPLES APPLIED

Fundamental principles were not merely accepted but were realistically applied. For example, assuming our objective as the best possible care at the patient's bed, we envisioned the enterprise in terms of the flow of materials, persons and services. Maximum service and minimum motion were constant goals. Coupled with these was, of course, the universal practical problem of minimizing costs.

How the building finally enveloped these principles and gave them expression in specific terms can best be seen by tracing the course of a typical operation that is representative of other hospital activities. While the handling of food is but one activity within a hospital, it is an excellent means for following traffic arteries.

We may begin with the road leading directly to the loading platform at basement level. At this point is the receiving office and arranged in order to conform with the food handling process are the dietitians' offices, refrigeration and storage facilities, the main kitchen and employes' cafeteria.

Because the precise form of service on various floors may differ, the whole plan is calculated to take greatest possible advantage of the central core principle to and from the first point of delivery. The central kitchen therefore begins with equipment to handle nineteen electrically heated food carts. Immediately accessible are two elevators that carry the carts to each floor. One centrally located serving kitchen is to be found on each floor. The carts are wheeled from the elevators directly to each of them. Equipped with modern facilities to keep the food warm, each serving kitchen has adequate space for employes to place the food on dishes, then on carts, and wheel them to the bedside.

After the food is served, the dishes remain in the serving kitchens where they are cleaned and stored. The electric carts go back to the basement kitchen where the installed containers are cleaned and the units are ready for use again. Each serving kitchen on each floor provides for four nursing units.

The special diet kitchen is located close enough to the main kitchen in the basement to enable it to time its movements accurately. But it uses electrically operated dumbwaiters instead of food carts and elevators. These dumbwaiters are adequate also to handle perishable foods from the adjacent salad preparation room.

Once the prepared food arrives at a floor, it does not uniformly follow the same dispensing procedure. For example, inasmuch as 50 per cent of the patients are ambulatory, there is a cafeteria on the third floor for 600 persons. The staff dining room adjoins it. Both are equipped with necessary food handling apparatus and both receive their food in the same manner as do the serving kitchens on other floors.

The employes' cafeteria, next to the basement kitchen, assures maximum efficiency in operation.

How the central core system can be adapted to varied needs is also illustrated in the isolation unit on the fourth floor. It operates in the same way as a floor serving kitchen, but pass windows, special equipment and a complete "break" provide necessary protection. Dishes do not move beyond the special serving kitchen in the isolation unit in which there is adequate means for their sterilization.

Another illustration of the flexibility of the overall arrangement is to be found on the eleventh floor where certain patients will be served individually in one room. Although the food is dispensed somewhat differently at this point, the unit receives its food in the same way that floor serving kitchens get theirs.

Study of the motion of food through the central core is an orientation in the multifarious uses of the principle. Inasmuch as the core is the main traffic thoroughfare, other services can be concentrated within it. They, too, will fan out to the ends of the floors.

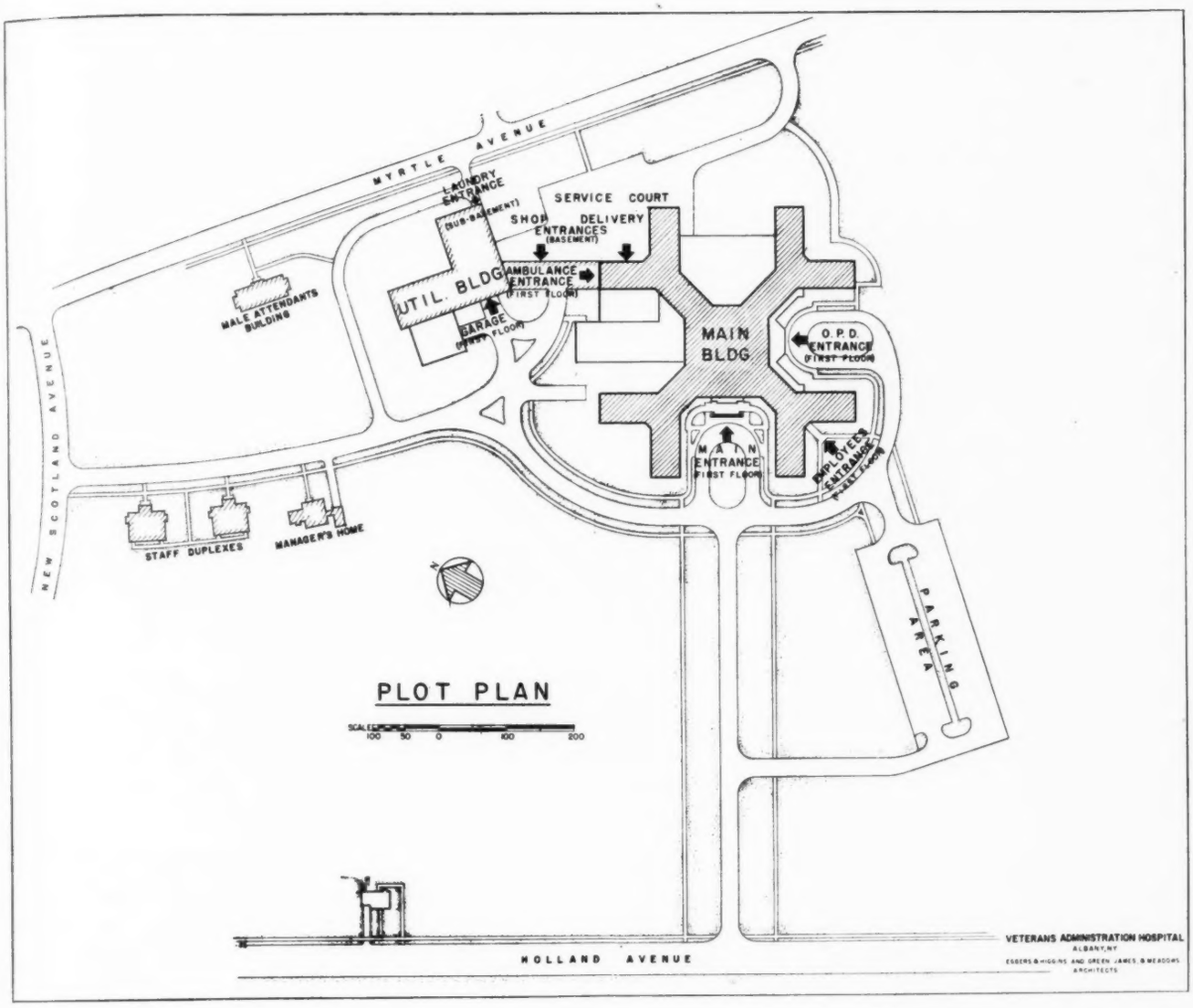
For example, sterile supplies come from the basement sources by electric dumbwaiter to the distribution rooms on each floor. These rooms adjoin the serving kitchens. All are within the core area.

LINEN ROUTE TRACED

Another example is the handling of laundry. There are clean and soiled linen closets for each nursing unit on each floor. Linens may be traced to and from the laundry. It will be seen that in every move, there is minimum motion. The laundry floor, at subbasement level in the utility building, is reached by corridors from the same level of the hospital building. Clean laundry is wheeled in well designed carts to the elevators, delivered to the floors, then to the four nursing units. Soiled linen can be rinsed in a utility room, thrust down a chute, and collected at four points in the subbasement on the same level as the laundry floor.

The flow of records and medicines in a hospital is just another traffic problem. Again, the core system makes it possible to knit together related facilities. In this case, the artery is a pneumatic tube system. From the pharmacy in the basement the pneumatic tubes shoot medicines to centrally located outlets on each floor. Tied to this pneumatic tube highway is the records office, which was strategically placed between the two sources of records, the outpatient and admitting departments. Records are dispatched through the tubes from the central office to the floors and back. In every case there are one artery and four service points.

Concentration of main traffic flow to the core is not limited to foods, sterile supplies, laundry, records and medicines. The elevators are in it, also. On one side are the visitors' elevators; on the other, five elevators, two for



Plot plan shows the relation of the main building to the service building, shops and ambulance entrance. A sub-basement corridor connects hospital and service building.

service functions such as food carrying, and three for the staff. The floor lay-out separates the passenger or visitors' elevators, with lobby and waiting room, from the utility elevators.

From these service elements, it will be seen that the central core principle, serving four nursing units, avoids duplication. One serving kitchen, one distribution room, one pneumatic tube outlet meet all needs where more might otherwise be required. Study revealed that they can practically serve four nursing units.

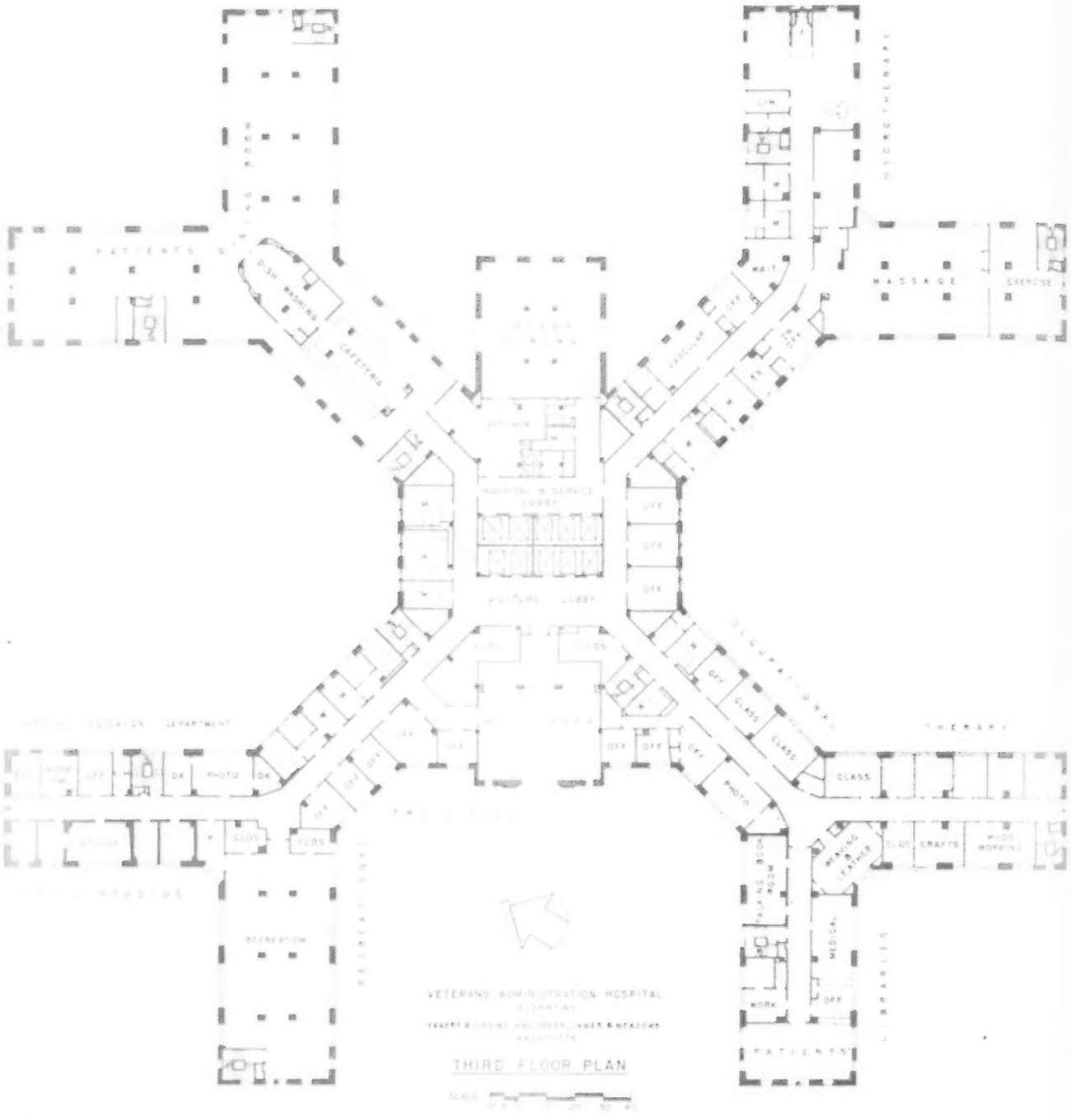
We may now proceed toward the final point of service, the patients' beds. Each of the four arms of the "X" constitutes a nursing unit. But the plan goes further. Each wing branches out into a "Y." Auxiliary service functions are housed in the stem of each "Y." Nurses' stations at the junction of each "Y" are ideally located to save steps and provide wide views of activity. Twelve single-bed rooms with toilets constitute one sector of the two arms; the other comprises three four-bed wards and one sixteen-bed ward. There are forty beds to a nursing unit.

Auxiliary services in the stems of the "Y" include a nourishment kitchen, doctors' offices and other essential facilities, linen closets, nursing unit supply closet, and a janitor's supply closet. Solariums are placed as far away from the beds as conditions permit, near the central core. This was decided upon by the Veterans Administration which requires patients to walk when they are deemed able.

A vital element in the whole arrangement is the person who works in the hospital. How does the plan affect the doctor and the nurse, for example? A glance at the service arrangements, at the location of their work places, will reveal that every effort has been made to enable them to concentrate upon accomplishment through saving of motion and time.

Four floors of the building, from the fifth to the eighth, inclusive, may be said to house the so-called typical nursing units.

A large area on the third floor is taken over by the occupational therapy department. Its facilities include three classrooms, a photography room, space for instruction in radio repair, painting, ceramics, printing and bookbinding, metal and jewelry work, woodwork, light crafts, weaving and leather work. All are laid out in one wing.



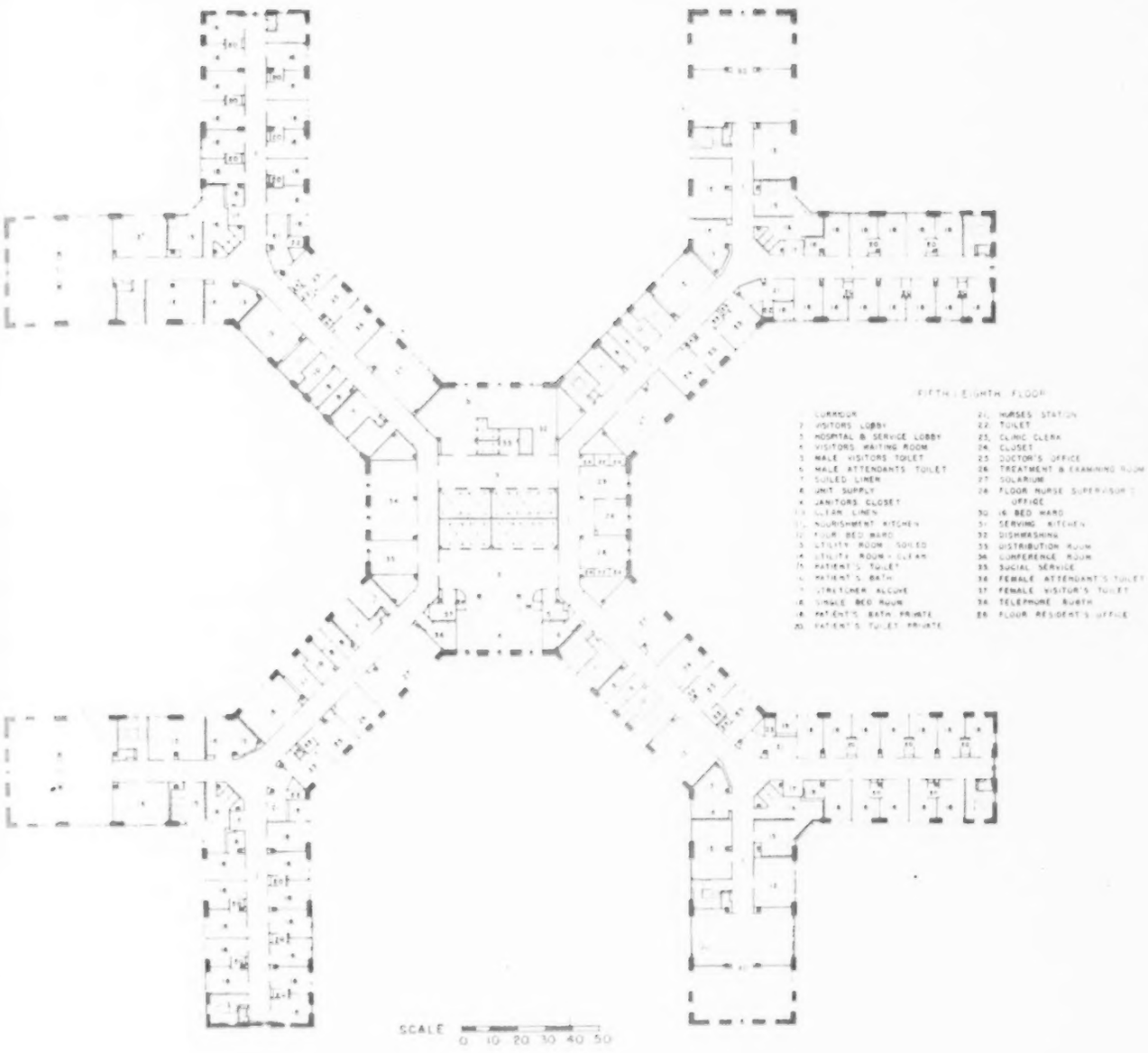
Libraries for the patients and the staff, a talking-book machine room for the blind, two large recreation rooms, three soundproofed music rooms for record playing and the radio broadcasting station are located in another wing. The radio room is the heart of a system that will permit great latitude in operation. Broadcasts can originate there and be piped outside the building or to the bedside. Likewise, outside broadcasts can be picked up and channeled to the patients.

Completely air conditioned, the operating suite on the second floor measures up to the modernity of the remainder of the building in all respects. There are nine major and five minor operating rooms, with a surgical recovery nursing unit. To round out the floor with related facilities, the laboratory wing and x-ray wing occupy the two remaining branches of the "X."

The ground floor, in the light of the facilities on the upper floors, is planned to meet administrative needs. The outpatient department is on this floor, with access to the floor above and the floor below for associated service facilities. The emergency and admitting units are likewise on the same floor, with a half dozen offices for the American Red Cross and other voluntary organizations. The Veterans Administration will occupy some of the office space and two rooms are set aside for chaplains.

Of the typical nursing unit floors, the fourth has the only real variation. One wing is devoted to the only women's nursing unit in the hospital, with twenty beds. Another is set aside for interns.

The eleventh floor, or first of the



VETERANS ADMINISTRATION HOSPITAL
ALBANY, N.Y.
EGGERS & HIGGINS AND GREEN, JAMES, & MEADOWS
ARCHITECTS

tower, is for the nursing staff quarters. Above the tenth floor are roof gardens that will be devoted to the nursing staff and patients. The remainder of the tower is used for a mechanical room, elevator and dumbwaiter machine rooms, with a tank room on top.

From the administrative point of view, the relationship of the service building to the hospital is vital, although it is not the only other building on the site. The service building is on Myrtle Avenue but adjoins the hospital building. A road leading to the hospital from New Scotland Avenue through the approximate center of the plot passes two duplex apartment buildings for the staff, and the hospital manager's residence.

The main entrance of the hospital is about 800 feet back from Holland Avenue. The male attendants' dormitory, housing eighteen men, is located at the far end of the site on Myrtle Avenue.

Facilities of the service building reveal it as a vital link with the hospital. They follow:

Subbasement. A corridor from the subbasement of the hospital leads into the same level of this building. Thus, soiled linen and waste emptying on the subbasement of the hospital building can be transported directly out to this floor. Here are the incinerator base, the first floor of the boiler room, the laundry room, locker rooms, toilets and showers for employes. Because of the slope of the land, one end of the floor is at grade on the Myrtle Avenue side.

Basement. The floor level is the same as the basement level of the hospital. On this level are the carpenter,

general, paint, plumbing and electrical shops, offices, a drafting room and clerk's office, mattress sterilizing and storage space. All are linked with operations inside the hospital building.

Other facilities include the animal room, cage cleaning room, locker room, toilets, machine room and second level of the boiler room. The shops front on a yard for delivery trucks.

First Floor. This floor houses the twenty-two-car garage for passenger automobiles and ambulances. At the floor level, on the roof of the shops below, is the yard into which ambulances may proceed for entrance to the emergency department. A portion of the floor is occupied by the third level of the boiler room.

The service building is roughly "T" shaped, measuring about 300 feet long on what would be the top of the "T," which is 46 feet wide at one end and 57 feet wide at the other. The stem of the "T" is 74 feet long by 73 feet wide.

Facilities for Living. In addition to the strictly hospital facilities, the plant is planned to provide facilities to serve patients, the staff and the public beyond immediate hospital needs. These are essential in a veterans' hospital. Space in the basement has been set aside for this. Here will be situated the necessary canteen, with a large kitchen, built-in refrigerator, a dining room 44 by 45 feet, a large salesroom and soda fountain. Other features include a barber shop, beauty parlor, tailor shop and similar service areas.

Planning this hospital required the closest kind of teamwork. It is a Veterans Administration hospital, and criteria were set up by the Veterans Administration. It is being constructed under the direction of the Corps of Engineers, New York District, 120 Wall Street, New York City. Full cooperation with them was necessary and accounts for the innumerable refinements characteristic of the building. We were associated in the architectural work with the firm of Green, James and Meadows of Buffalo, N.Y.

While this administrative organization in planning obviously required joint thinking and action throughout, it was all the more necessary when it is considered that the plans for the Albany Veterans' Hospital building are virtually identical with those of the Buffalo Veterans' Hospital.

Despite the close similarity of plans, site conditions required quite different treatment of auxiliary buildings. This was especially true of the service building where grade conditions created a problem wholly different in Albany from conditions in Buffalo.

Again, subsoil conditions in Albany were most unusual. Although the hospital building is at the top of a pinnacle, it rests on H-shaped piles, with piles driven to bed rock. The slope was used to create three entrance levels in the rear so that service automobiles and trucks could be drawn directly into the proper levels to fit perfectly into corresponding levels within the service building and the hospital itself. Thus, ambulances run straight to the emergency department over the roofs of the shops and delivery trucks come right to the floor level of shops and food-handling facilities of the hospital.

The advantage of group planning on these two projects resulted in the ultimate emphasis on administrative needs. Our objective is a synthesis of scientific planning to meet realistic problems of management and control. Perhaps this, as much as any other factor, enforced the simplicity of pattern finally adopted.

Again and again, throughout the preliminary stages of planning, we were confronted with the complexity of service required in a hospital of this character and the urgency of cost of operation. Weighing all known factors, our emphasis was placed upon a design that would feed out to the largest practicable number of nursing units, without impairing efficiency, from the best possible concentration of traffic arteries. We think that the "X" form met this challenge.

INTERIOR OF THE LOBBY AS THE ARTIST ENVISIONS IT

REFORMS IN TENURE ARE LONG OVERDUE

MAXIM POLLAK, M.D.
Veterans Administration Hospital, Downey, Ill.

BUILDINGS and equipment do not make a hospital, just as a house and its furnishings do not make a home. The spirit that dwells within the portals of the buildings, the skills with which the art of healing is practiced, and the understanding with which the various needs of the sick are attended to are the essentials that create a pulsating human organization for the care of the sick. In such an organization the administrator shoulders the responsibility of leadership and command. Thus, no hospital can be better than the administrator at its head.

In recent years we have made tremendous progress in preparing the administrator for the responsibilities he has to face, when we turned from the apprentice type of training to systematic studies on a professional level. But training and experience in themselves are not enough to permit the administrator to develop his capabilities and do his best for the sick under his care.

FAVORABLE CLIMATE NEEDED

A favorable climate conducive to work at a high professional level is a prerequisite without which even the best prepared and qualified administrator cannot succeed. Unfortunately, in the preparation of such a climate we have made but little progress. Instead of exploring the factors which are essential to successful administration and presenting them to the proper authorities who hold the reins of our hospitals in their hands, we have left everything to chance and to the hope that these powers are filled with wisdom, sound judgment and expert understanding.

Hospitals, be they voluntary or tax-maintained, are public undertakings. Their management, as a rule, is entrusted to a board, either elected by the supporting organization, or appointed by a public official, as is the case with tax-supported institutions. Were members of such boards selected according to fitness and experience in management, the well qualified administrator would have little to fear. This, however, is rarely the case, particularly with the small hospitals in small communities.

Moreover, the present trend in selecting board members for welfare institutions is in the direction of selecting a group in which the various segments of the community are well represented. While such practice is desirable for various reasons, nevertheless it leaves much to be desired as far as fitness in management is concerned.

Curiously enough, even business men when appointed to the boards of "charitable" institutions often forget that sound business practices, such as proper cost accounting, bookkeeping and the like, are just as essential in the management of welfare organizations as they are in any business enterprise. Often such practices are objected to on the ground that they do not show any direct return as far as the "charitable" objectives are concerned.

It is well known that in the appointments of many of our public institutions politics prevail. It should not be forgotten, however, that politics are played not only in city halls, courthouses and state capitols, but not infrequently also among the members of the respectable boards of our voluntary hospitals. It makes but little difference that in the last instance it is not the workers of various political groups who are favored, but personal prejudices and preferences, far afield from the interests of proper hospital management.

As things stand today, no provisions exist which would assure the conscientious and well qualified administrator that as long as he performs his duties in the best interest of his patients, he will remain secure in his position. No wonder that the turnover of the administrators of many hospitals is much greater than it need be. Under such circumstances, neither the welfare of the patients nor the future of the administrator is protected.

The public learned many years ago that if it wants to attract employes of the proper caliber to serve it adequately in federal offices, it must assure them of security in their jobs. Enlightened public opinion forced the enactment of the Civil Service law. Under the provisions of this law no Civil Service employe can be dismissed unless charges have been preferred against him and adequately proved. Under the protection provided by this law the federal government has been able to attract men and women of outstanding caliber to serve their country at a fraction of the salary they could command in business.

A.C.H.A. SHOULD CONSIDER PROBLEM

In the field of higher education it was the American Association of University Professors, a voluntary organization, which was instrumental in providing security for the college teacher, employed by public and private organizations, not unlike our hospitals, without the compulsion of a law. The time has come, we believe, for the professional organization of the hospital administrators, the American College of Hospital Administrators, to devote some attention to the tenure of its members.

Tenure, says Webster, is "the manner in, or the period for, which anything is had and enjoyed." Under this definition, both the manner and the period are equally essential. It goes without saying that no professional organization will, or even can afford to, protect a member who is incompetent to hold the position he fills. Thus, the first step in dealing with tenure would be the determination of qualifications that mark a good administrator.

It is of equal importance to delineate the administrator's authority, his prerogatives and duties. This is a field in which considerable difference of opinion exists not only between

hospital boards and administrators, but even among administrators themselves. This is also the field in which friction between boards and their administrators is commonest.

Before one can establish safeguards for future contingencies, it is imperative to explore present day practices against which protection is sought. Perhaps the most serious difficulties arise from the fact that there exists no recognized authority to which boards and administrators alike could turn with equal confidence whenever friction ensues between a board and its administrator. Little irritations, caused by misunderstanding a justified point of view, often lead to serious friction and finally a break between a board and its administrator. Could a trusted mediator be called upon for help in time, tempers and emotions would often not reach a boiling point, and differences could be adjusted readily to the benefit of all concerned, including, first of all, the patients.

LET'S HAVE PUBLIC HEARING

Often, boards act arbitrarily because there is no one who could censor their action. Board meetings, as a rule, are conducted in private, without the salutary effect of full publicity. Many a board member would think twice before acting as he does, should he have to justify his action. Airing grievances in the press after an injustice has been committed will seldom help the administrator. On the contrary, such procedure may further injure his reputation because he could easily be accused of being a trouble maker. Should it be required, however, that no administrator could be dismissed without the benefit of a public hearing, at which the administrator could present his side of the story and the board be questioned in regard to its motives, no doubt, many a discharge could be easily prevented.

Because there are many ways by which the position of an administrator can be made intolerable, there should exist a forum which enjoys the confidence of administrators and boards alike to which grievances could be carried with the full expectation that they would be arbitrated without prejudice or bias. By such peaceful means administrative practices could be materially improved upon in many a hospital.

As long as hospitals serve as educational institutions in the training of nurses, interns and residents, it is imperative also from an educational angle that they be administered in a manner that is above reproach. Young people are particularly observant and impressionable and view their environment with critical eyes. The shortcomings of administration can hardly be condoned before those who work within the hospital's walls.

The sensitive student can only be painfully impressed by the effects poor management has on the welfare of the patients. On the other hand, the less scrupulous may learn by precept that efficiency is not a prerequisite to success. Such an attitude is bad enough in any walk of life, but it might become disastrous in the practice of the healing arts. For this reason the accrediting agencies, such as the Council on Medical Education and Hospitals of the American Medical Association and the American College of Surgeons, could pay greater attention to the caliber of the hospital administrator and the efficiency of the management in their requirements for the recognition of a hospital than is the practice today.

Reference has already been made to the successful efforts of the American Association of University Professors in safeguarding the tenure of the college teacher. This association was organized in 1915, as stated in its Constitution, "to facilitate a more effective cooperation among teachers and investigators in universities and colleges, and in professional schools of similar grade, for the promotion of the interests of higher education and research, and in general to increase the usefulness and advance the standards and ideals of the profession."[1]

In an extensive study[2] of the status of the profession of the college professor, Logan Wilson, professor of sociology, Tulane University, stated that "since its formation the association has concerned itself actively with the general welfare of the profession." Mr. Wilson added that "though the association is organized for many purposes other than making adjustments in conflict situations, it is the sole available professional agency of this type for most of the group, and hence inevitably finds itself confronted with a large number of such cases.

"Its codes provide enactment for guidance in such situations, its officers are prepared to act in a judiciary capacity, and, in addition, there are sanctions which may be brought to bear upon the offending institutions. . . . It is logical that the professional association should assume employe protective functions which otherwise would devolve upon no organized group. . . . Most of the cases coming before the A.A.U.P. Committee on Academic Freedom and Tenure are from the 400 smaller colleges. (In 1932 one of every six smaller institutions of learning had a case appealed to the General Secretary or to the Chairman of Committee A.)"

"In 1925, at a conference called by the American Council on Education, there was formulated a statement of principles concerning academic freedom and tenure. Participating in this conference were representatives of the American Association of University Professors, the American Association of University Women, the American Council on Education, the Association of American Universities, the Association of Governing Boards, the Association of Land-Grant Colleges, the Association of Urban Universities, and the National Association of State Universities. The statement of principles formulated and agreed upon in this conference, known as the 1925 Conference, Statement on Academic Freedom and Tenure, was endorsed by the Association of American Colleges in 1925 and by the American Association of University Professors in 1926."[1]

APPLICABLE TO ADMINISTRATORS

Pertinent provisions concerning tenure applicable to the hospital administrator are as follows: "The precise terms and expectations of every appointment should be stated in writing and be in the possession of both college and teacher. . . . "In all cases where the facts are in dispute, the accused teacher should always have the opportunity to face his accusers and to be heard in his own defense by all bodies that pass judgment upon the case. In the trial of charges of professional incompetence the testimony of scholars in the same field, either from his own or from other institutions, should always be taken. Dismissals for reasons other than immorality or treason should not ordinarily take effect in less than a year from the time the decision is reached."[1]

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[1]Bulletin, American Association of University Professors, Spring 1947, 33:161.
[2]Wilson, Logan: The Academic Man. Oxford University Press, 1942.

In 1940, the Commission on Academic Freedom and Academic Tenure in joint conferences with the officers of the American Association of University Professors formulated a "Statement of Principles," which was later endorsed by the Association of American Colleges. Among other things, the resolution was adopted that "Tenure is a means to certain ends; specifically: . . . a sufficient degree of economic security to make the profession attractive to men and women of ability. Freedom and economic security, hence tenure, are indispensable to the success of an institution in fulfilling its obligations to its students and to society."[1]

SECURITY IS ESSENTIAL

The reading of Mr. Wilson's book and of the Spring issue of the *Bulletin* will be profitable for every hospital administrator interested in his own welfare and that of his patients. Because, after all, the security of the administrator and the welfare of his patients are inseparable. No administrator can perform his best unless the climate in which he moves is conducive to good work, and to this end the knowledge that his future is secure as long as he performs his duties in a satisfactory manner is essential.

Reading Mr. Wilson's book one is struck by the large number of studies from which he quotes, all dealing with the security of the teacher, particularly when one contrasts the paucity of material dealing with the security of the hospital administrator. That the Association of University Professors considers tenure of prime importance is underscored further by the fact that it excludes from its membership all the administrative officers of the colleges, because they may represent the point of view of the governing boards and thereby use their influence against the interest of the teachers.

The large number of organizations in which the governing boards are banded together is also striking. No such organizations exist in the hospital field. At present there is no organization which could speak authoritatively for, or officially represent, the hospital trustees. Yet certain employe groups, notably the nurses, make their demands through their national and state organizations and expect compliance on the part of all hospitals. Negotiations with such organizations could often ease existing tensions and clear up misunderstandings, but the state associations and the American Hospital Association cannot enter into negotiations which would even morally bind the governing boards of the hospitals. This is a shortcoming which calls for remedial efforts. Perhaps the full development of the trustee section of the American Hospital Association could be made the first step in this direction. Such a development would also kindle the much needed interest of hospital trustees in problems of management, for which they shoulder the responsibility.

Summing up what has been said we come to the following conclusions:

1. Tenure of the administrator is essential to the welfare of his patients.

2. No organization should condone or protect the inefficiency or incompetence of the administrator under the pretense of tenure.

3. For this reason it is necessary to codify the qualifications of the good administrator and the criteria of good administration.

4. To avoid misunderstandings it is necessary that the prerogatives and duties of the administrator be clarified and codified in relation to those of the board of trustees.

5. An unbiased forum needs to be established which should mediate misunderstandings arising between administrators and hospital boards. The decisions of such instrumentality should be binding on both parties.

6. Sanctions need to be provided for the offenders on either side.

7. Before negotiations could be conducted which would place obligations on the governing boards in general, an organization of such boards needs to be established. For this purpose the trustee section of the American Hospital Association should be fully developed, so that it may act authoritatively in the behalf of such boards.

8. The accrediting agencies, *i.e.* the Council on Medical Education and Hospitals of the American Medical Association and the American College of Surgeons, should pay particular attention to the caliber of the administrator and the efficiency of management in their requirements for the recognition of a hospital.

9. The American College of Hospital Administrators, as the representative organization of the hospital administrators, is the agency which in the joint interest of its membership and the welfare of hospital patients should press for the long overdue reforms in the tenure of the administrator.

The constitution of A.C.H.A. (Article XI, Section 6) authorizes the executive committee to "make inquiry concerning the factors involved in the dismissal of a fellow or a member from his position and may take such action as the investigation may indicate to be desirable in respect to his membership or fellowship in the College."

Students Vote for Double Rooms

SOME time ago, Presbyterian Hospital, Chicago, sent a questionnaire to its student nurses, asking which of three forms of accommodations they would prefer, in the event that the hospital rebuilds its nurses' home.

1. All double rooms with sleeping, dressing and study equipment for two students in each.

2. Two students in a study room with all equipment except the bed in each. Nurses would sleep in a separate dormitory-like room with perhaps four people sleeping in one dormitory.

3. Very small single rooms with sleeping, dressing and study equipment for one student.

Of the questionnaires that were returned, thirty indicated a preference for the first type of room; one liked the second idea, and nineteen voted for the third.

This response seems to indicate that the average age of students is lower than that of earlier generations of nurses and inasmuch as many students are away from home for the first time they prefer to have the companionship of a roommate. At least, this is the way we have interpreted it.—LESLIE D. REID, *superintendent, Presbyterian Hospital, Chicago.*

AN OUNCE OF PREVENTION IS WORTH THOUSANDS OF DOLLARS

DON C. HAWKINS
Assistant Secretary
St. Paul-Mercury Indemnity Company, St. Paul, Minn.

THE subject of accident prevention and safety is of great importance to hospitals, and the large number of law suits brought annually in each state should be a warning. The maxim "An ounce of prevention is worth a pound of cure" has special significance and application in this case, and yet how can those who are responsible for the administration of an institution and their employes prevent the calamity of a malpractice or personal injury suit if they are not informed of the principles which should govern their conduct in this phase of administration.

There is no better way to avoid mistakes and errors than to know the mistakes and errors which have caused other institutions trouble and expense.

In a recent case in a southern state, a doctor instructed the operating room supervisor to prepare the tray with a solution of 1 per cent novocaine. The nurse states that she understood the doctor to say "cocaine." The doctor filled his 7 ounce injection needle with the solution, which was introduced into the tonsils. The throat immediately became paralyzed, convulsions set in, and the patient died within a few minutes. The nurse had prepared 1 ounce of 5 or 10 per cent cocaine. In another case, injuries were sustained by a child 15 months old, who had entered a hospital for an eye operation. The resident doctor of the hospital applied a tourniquet on the upper arm at approximately 3 p.m. on the fourth of the month in order to make a blood test. He forgot the tourniquet and it was not removed until twenty-four hours later. The result was that the child has lost for all time the use of that arm below the elbow.

Needless to say there are numerous cases of carelessness and negligence which can be avoided. In reality, only 10 per cent of all accidents are due to so-called acts of God or conditions beyond control. The other 90 per cent are not truly accidents but are caused by human failures and carelessness. Undoubtedly, regular inspections by safety engineers are of great value in decreasing the number of accidents but it is the attitude toward safety on the part of every person within a hospital, regardless of whether he is patient, visitor, intern, employe or administrator, which prevents a large number of accidents due to the hidden hazards. Inasmuch as hospitals have always been considered a place in which to treat accidents and not the place to have them, little thought has been given to developing a constructive attitude toward the prevention of accidents. Many changes have come about here, however, as they have everywhere else.

Regulations regarding almost every activity are being introduced. Directly or indirectly, hospitals are affected by bills relating to hours of labor, wages, taxes, the use of drugs, medical procedure, supervision and dozens of other problems. This same influence has changed the public's attitude toward social problems and their solutions. Social security, bureaus for economic improvement, concern with occupational hazards, relief to millions of citizens, and lien laws in accident cases are but a few of the situations about which our forebears had no need to worry. Today, every one of these and many others like them have direct and important bearing on the hospital, whether it is supported by taxes or private funds.

A campaign for the prevention of accidents can be carried out as successfully by hospitals as it can in other industries if there is a will to do so. While the program of one hospital will vary in some details from the programs of others, certain principles accepted by safety directors apply generally in nearly every case. There should be the same executive interest and participation in accident prevention that there are in other business routines. Responsibility for results should be clearly established. System and procedure are necessary in safety work, but only as a means to an end. The prevention of accidents is most effective when it is understood to be the application of managerial and supervisory pressure.

The major causes of accidents, according to a survey and a study of claims, are: falls, burns, explosions and accidents arising out of maintenance. These represent only the physical sources of accidents. Malpractice is another category and is not at all well distinguished from these physical accidents. Some cases have been handled as malpractice which resulted entirely from physical failure and would not normally be considered as malpractice by the hospital. Falls and burns are the most frequent and probably the most costly from a standpoint of claims.

Floors are always a problem and hospitals everywhere wonder what wax is the best and what flooring is the safest. Claims have been made by

manufacturers that they produce a nonslippery wax and a number of experiments now being carried out indicate that these claims are true. However, good wax properly applied is not dangerous; it should be applied lightly and worked in thoroughly. Gleaming waxed floors are no longer in vogue and a lot of nasty falls can be traced directly to them. Too much water on linoleum usually soaks through the joints and rots the burlap base, but lightly used, water does a good job of cleaning.

Poor stair treads are a common source of danger. Brass nosing and carpet runners need constant supervision if bad falls are to be prevented. Abrasives in the concrete make a safe stairway. All stairways, especially those leading down behind closed doors, are traps and should be well lighted and warning signs should be placed on the doors. One hospital recently reported two bad falls on such a stair in one month after it had turned off the lights to save on the electric bill.

Broken or patched ladders or chairs in storerooms should be destroyed.

Falls from bed are a source of injuries and they should not be overlooked. Studies have been made which classify these falls into age groups, time of day, type of patient and sedatives given. These are helpful but not conclusive. Such studies do indicate that falls occur in all groups, with or without side rails. Commoner use of bed rails seems to be needed. Ease of operation is important, as nurses are only human and many a heavy, clumsy rail is left off merely because it is a tough job to put it on. Patients whose condition requires that rails be placed on the bed should never be left alone, even briefly, when the rails are not in use. In one case, a patient in labor was left this way when the nurse turned to answer a knock at the door. Before the door had been opened, the patient turned, fell to the floor and fractured her hip.

The argument is true that patients who fall over bed rails fall farther; still, if the patient's condition calls for rails and if he is injured while crawling over the rail, the hospital has nevertheless applied the precaution of the safety measure which eliminates any accusations of negligence on the part of the hospital. In most cases of this kind, it is usually recommended that the chart be marked that the patient was out of bed without permission, thus placing the burden of proof on the patient.

Wheel chairs that tip over when patients reach forward or step on the foot rests are common sources of falls. There are several inexpensive anti-tip legs that fit most types of chairs and should be placed on all wheel chairs.

Burns, which occur as frequently as falls, are most commonly caused by hot water bags and electric pads. There has been a difference of opinion as to the degree of temperature which it is safe to use in hot water bags, but it has been determined that 120° F. is a maximum. The old practice of guessing at the heat, testing it with the elbow or wrist, merely taking a chance, which is a commoner practice than is thought, has cost thousands of dollars and has resulted in untold suffering.

In a study of one group of claims, it was found that 55 per cent were caused by hot water bag burns, and these cost about half of all the claim payments. The percentage would probably not be generally true but it does indicate what can happen in a hospital when the guessing rule is used. Under no condition should a hospital purchase or use electric pads which do not carry the Underwriters' Laboratory approval. Many hospitals have eliminated the use of electric pads with great success and many that do use them use only the molded rubber type which carries the Underwriters' Laboratory approval.

It should be pointed out that the supervisors and the directors alone cannot eliminate these burns and falls; it takes the wholehearted cooperation of everyone to observe and correct these potential causes of accidents.

Explosions in surgery are not numerous but they are often fatal, and they result in unfavorable publicity and much worry. A recent survey, using as a sample 60 per cent of the available beds in the United States, indicates that there were probably seventy-two explosions last year which resulted in twelve deaths. This was an increase over the figures of 1945.

The Massachusetts Institute of Technology under the direction of Prof. J. Warren Horton, has contributed to our knowledge of means and control of the hazards attending the use of anesthetics.

The following are a few of the safeguards recommended:

1. Any cylinder or container used for storing an anesthetic should be clearly marked with the name of the anesthetic it contains.

2. Too much importance should not be placed upon the color of the cylinders. The anesthetist should always look at the label and consider the color of secondary importance. Cloth covers for cylinders are likely to hide the identity of the gas they contain and therefore should not be used.

3. Cylinders or cans containing anesthetizing gases or fluids, or other gases used for medical purposes, should be stored in dry, well ventilated locations. Under no circumstances should they be stored in operating rooms.

Needless to say, the provisions of state laws or municipal ordinances governing the storage of compressed gases and inflammable liquids must be complied with.

High humidity as a means of reducing static spark appears to have

considerable merit. Areas which enjoy high humidity are singularly free from static explosions while dry sections have had serious ones.

The dry cleaning industry was faced with a comparable problem and found that the maintenance of a relative humidity of 60 per cent was adequate. This relative humidity was taken to be adequate for operating rooms but at least one explosion has been reported as having been due to static in the presence of a relative humidity in excess of 60 per cent. Moisture is a conductor and the film developed on all objects in a room in which the air is moist tends to carry off charges and thus maintain a balance. It seems advisable for this reason to maintain the humidity in surgery rooms at 60 per cent or higher if possible.

Light switches, wall sockets and light bulbs in surgery are commonly of the sparking or exposed type. Mercury switches are not costly and can be installed in place of the old switches by the hospital engineer. Explosion-proof sockets are expensive if many are needed. Sparks at the sockets, unless they are broken or worn, occur when the plug is pushed in or pulled out; these can be avoided by the use of the inexpensive lock type of socket and plug which cannot be jerked out or pulled out by stumbling over the cord, or unless they are deliberately disconnected.

Thousands of exposed electric light bulbs are on the walls and are even in use as operating lights in many hospitals. A bulb or cluster of

these lights can develop heat well above that required to cause an explosion. In one hospital, three bulbs exploded directly over an operating table and showered the table and the floor with glass. There was a patient on the table at the time.

All flames and heaters should be kept out of surgery. Bulbs should be covered and the ones not absolutely needed should be removed. Any attempt to use electric cauteries with explosive anesthetics should be prevented.

A sure place to find ether in a hospital is in the laboratory—next to a Bunsen burner. Carbon tetrachloride should be substituted and ether should be prohibited except for an anesthetic. A few pathologists have objected to carbon tetrachloride because of poisonous fumes. Some deaths have been caused when it was used in large quantities and the fumes were inhaled but the quantity used in a hospital is so small that it does not even require a government safety label.

Many of the younger superintendents have no idea that nitrate film is dangerous and some do not even know that such a film exists. If this film must be used in the hospital, it should be stored in an approved vault and preferably away from the main buildings.

The proper maintenance of an institution does much to eliminate accidents. For instance, most operating lamps are heavy and are suspended from the ceiling by some type of anchor. The lamps are turned and pulled constantly and this affects the anchors, but they are in a place that is hard to reach and are rarely checked. There are three instances on record in which the lamps have fallen and in two of them, the patients were on the table, which is sufficient evidence that they should be watched, and if possible, the bolts or screws should be treated so that they cannot come loose.

OTHER CAUSES OF ACCIDENTS

Other cases of faulty maintenance which resulted in serious injuries are: a loose pivot bolt on the head section of an operating table fell out and allowed the section and the patient's head to drop during an operation; a counterweight cable holding the tube on a large x-ray therapy unit came off when a loose bolt came out and dropped the heavy tube on the patient below; a door lock on an elevator was out of order when a patient opened the door by mistake and fell down the shaftway to her death.

It takes no stretch of the imagination to see that most of these accidents result from things which could have been repaired in a short time, and regardless of whether the hospital pays the cost of the claim directly to the patient, the visitor or the employe or indirectly to the insurance company in the form of a premium, it still must pay the claim. The higher a hospital's accident rate is, the higher will be the premiums for that hospital.

If the tendency to eliminate the immunity of charitable institutions from liability suits continues to spread, it would indicate that a safety program in a hospital is of vital importance.

DO UNTO EMPLOYES AS THE UNION WOULD DO

But Do It First

S. A. RUSKJER

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IN THE past, hospitals have customarily employed a larger number of women than they have men. During the recent war years, women entered many fields of employment formerly occupied by men. That trend has been carried over into the postwar period. On Jan. 1, 1947, there were 17,000,000 women employed in nonfarm jobs in the United States compared with 15,000,000 so employed three months earlier. The percentage of jobs held by women dropped from 40 per cent on V-J Day to 31 per cent by the middle of 1946, held steady for a time and then began to rise again.

During 1946, 110,000,000 man days of work were lost because of stoppages by strikes, thus trebling all previous records. Such is the condition of unrest and uncertainty in the field of employment from which the hospital must recruit its employes, facing keen competition from powerful commercial enterprises.

WAGES TAKE SIXTH PLACE

In a large scale survey recently conducted to discover the problem or interest that lies closest to the heart of the average American worker, the item of salaries or wages took not first but sixth place. Of greater concern to the average employe than current financial income were listed such items as: (a) old age security, (b) social security, (c) vacations with pay, (d) opportunity for further study and advancement, (e) improved living conditions, (f) provision for recreation and physical fitness, (g) assurance of medical care and hospitalization in case of need for the worker and dependents, (h) uniforms suitable to the work performed, (i) working hours that permit living a normal life, and (j) removal of work hazards.

Hospital management can ill afford to ignore the reasonable desires and requests of employes if it is to succeed in carrying forward a successful program. Early attention should be given to such basic considerations as the following:

1. Elements of a good job analysis, including content and application.
2. A carefully developed job evaluation.
3. Employe motivation and general morale—discovering causes of unrest or dissatisfaction and finding a remedy that is fair and just.
4. Employe's welfare, giving special attention to health service, pension plans, sick leave policies and vacations with pay.
5. Exercising greater care in the selection, orientation and placement of employes to achieve the most satisfactory results.
6. Giving a balanced attention to preliminary and concurrent training program, making use of hospital training manuals.

The hospital is not a commercial enterprise but a public service institution. Labor unions are not greatly interested in organizing public service institutions, but unless the hospitals set their own house in order, rest assured that they will sooner or later be involved in labor disputes.

It is well to keep in mind that if the employes in the hospital feel they have real grievances and that nothing is being done about those grievances, the hospitals, through such neglect, are virtually encouraging the employes to invite the intervening help of organized labor in their behalf. It is also well to remember that in that event, the hospital will be dealing not with one but with many unions. The world's largest hotel has 2200 employes, of whom 97 per cent are unionized by twenty-one different labor unions.

Most union leaders recognize the fact that hospital workers cannot strike and are willing to include a no-strike clause in the contract, but that does not obviate the difficulties, for if hospital workers are unionized and decide that the hospital is unfair to them, even if they cannot and do not strike, sympathizers can throw a picket line around the hospital, which automatically shuts off all sources of supplies. Organized truckers, for example, will refuse to cross the picket lines to deliver even necessary foods to the institution. In considering hospital personnel, we have to think of not only medical and nursing employes and technicians but engineers, housekeepers, window washers, laundry workers, plumbers, carpenters, steam fitters, and firemen, and it is of the greatest importance that continuity of service in these departments be an assured fact.

HOW TO AVOID DIFFICULTY

The question may well be asked, "what can hospital leaders do to avoid any serious difficulty with organized labor?" The answer is "they can do much in every way." They must get there the "firstest" with the "mostest" in order to lick the problem. It would be well to discover first what the benefits are that the unions would attempt to bring to your employes and then beat the unions to it by supplying those benefits at the earliest possible date, giving attention to the following items:

1. Remove all working hazards.
2. Provide suitable working conditions, giving attention to space, light, air.
3. Provide a salary commensurate with salaries paid in comparable positions in the trade area of the hospital.
4. Provide sick leave with pay.
5. Provide for legal holidays and a suitable vacation with pay.
6. Make provision for educational advancement and promotion.
7. Provide a reasonable work week.

8. Give necessary attention to physical check-ups and health needs.

9. Create a proper outlet for expression of grievances.

10. Provide opportunity for personnel to make suggestions for improvements.

11. Create a pleasant employer-employe relationship.

12. Encourage necessary recreation, if possible providing the facilities.

13. Encourage a pleasant family atmosphere within the institution.

14. Hold meetings with all department heads and group meetings for personnel in the various departments.

15. Provide seasonal parties.

16. Avoid terminating an interview with any employe while he is still angry.

17. Encourage all department heads to lead and not drive.

Hospital administrators should not look upon leaders in the field of organized labor as being enemies of the hospital. They can be a definite asset if the hospital management will endeavor to adopt and adhere to the highest ideals for which organized labor stands.

ACCOUNTING SHORT CUTS

Pay Roll Procedures

ROBERT PENN
Accounting Consultant, Chicago

CHANGE OF POSITION OR SALARY OF EMPLOYE:

AS STATED in the first article of this series, a pay roll clerk is generally racing against time in order to meet a deadline for the issuance of the pay roll checks. It is, therefore, important that the pay roll clerk be advised of all changes during the pay roll period some time before the end of the period so that the clerk can promptly record the changes on the appropriate forms. Running down differences or trying to trace changes when computing the pay roll is quite time consuming and annoying to the pay roll clerk, to say the least.

To avoid any question as to increases in salary or changes in position it is advisable that such changes be recorded on a form provided for that purpose and signed by the department head and approved by the administrator.

NOTICE OF DISCHARGE OR RESIGNATION:

The comments on change of position or salary of employe apply equally to the notice of discharge or resignation of employe.

The information shown on this notice should be recorded on both the employe's record and the employe's earnings record.

PERSONNEL STATISTICS:

Inasmuch as pay roll expense is a large segment of the total operating cost—ranging from 55 to 60 per cent of total operating expenses—it is important to have a statistical analysis of the pay roll to be used in conjunction with monthly financial reports. However, in order intelligently to interpret the pay roll expense, it is necessary that it be analyzed as to productive and nonproductive time, the latter being time paid by the hospital for which the employe has not worked.

The schedule of personnel statistics will, we believe, help management understand the increase in pay roll expense during vacation months when frequently the hospital not only has to employ relief employes, but also has to pay for the vacations of full-time employes. During such periods there might conceivably be a drop in occupancy, causing a decrease in income, yet there may be an increase in cash outlay for pay roll expense.

CHANGE OF POSITION OR SALARY OF EMPLOYEE

Date June 18, 194 7

Name Jean Jones Dept. Administration

Present—Position Cashier Cash Salary $150.00 Per Month

Other Compensation 1 Meal a day Per Month/Week

New—Position Cashier Cash Salary $155.00 Per Month

Other Compensation 1 Meal a day Per Month/Week

Effective Date of Change July 1, 1947

Reason Efficient and conscientious

Signed S. Thomas (Dept. Head) Approved M. Phillips (Supt.)

To be sent to Superintendent FOR APPROVAL, and upon approval to be sent to BOOKKEEPER

DISCHARGE OR RESIGNATION OF EMPLOYEE

Date Dec. 10, 194 7

Name Jean Jones Dept. Adm.

Position Cashier Effective Date of ☐ Discharge ☐ Resignation Dec. 31, 194 7

Reason Family moving to California

	Excellent	Good	Fair	Poor
Quality of Work		X		
Industry		X		
Initiative		X		
Character	X			
General Efficiency		X		

Do You Recommend for Re-employment? Yes

In Your Dept.? Yes

In Other Depts.? Specify

Did You Recover All Hospital Property? Yes

Signed S. Thomas (Dept. Head) Approved by M. Phillips (Supt.)

To be sent to Superintendent FOR APPROVAL, and upon approval to be sent to BOOKKEEPER

If it is the policy and practice of the hospital to pay for vacations of full-time employes, we suggest that a reserve for pay roll be set up on the books monthly. This can be readily computed and charged each month to the departmental expenses and credited to a reserve. The salaries paid for vacations should then be charged to the reserve accounts and at the end of the fiscal year the reserve accounts can be adjusted. For example, if the hospital allows an employe two weeks' vacation with pay, that is approximately 4 per cent of the employe's annual salary. Therefore, each month there would be charged to the department account 4 per cent of the employe's cash salary and the reserve would be credited accordingly.

The effect of this is to charge each month with its proportionate share of vacation expenses and thereby reflect the current expenses more accurately and eliminate from the months that can ill afford it the cost of vacations. A further advantage is that costs are more accurately determined when the hospital is reporting to various agencies on a semiannual basis. (*Note:* For definitions of productive hours, overtime and so forth see instructions on personnel statistics.)

PERSONNEL STATISTICS

Jan 1 to Jan 15, 1947

Department	Employed: Full Time No	Full Time Days	Part Time No	Part Time Days	Overtime: Full Time Prod. No	Full Time Prod. Days	Full Time Non-Prod. No	Full Time Non-Prod. Days	Part Time No	Part Time Days
Nursing Service:										
Graduate nurses	4	58			12	156	1	5	2	10
Nurses' aides					7	91				
Hospital aides					5	65				
Student nurses										
Total	4	58			24	312	1	5	2	10
Medical and Surgical Service										
Medical Records and Library					1	13				
Nursery					1	13				
Special Services:										
Operating room	1	13			1	13				
Delivery room					1	13				
X-ray	1	13			2	26				
Laboratory	1	13			1	13				
Pharmacy	1	13			1	13				
Physical therapy	-	-			-	-				
Total	4	52			6	78				
Administration	3	39			4	52			1	5
Dietary	3	39			7	91	1	2	3	15
Laundry	2	26			2	26			2	10
Housekeeping	2	26			6	78			2	15
Heat, Light, Power and Water					2	26				
Maintenance and Repairs					1	13				
Total	9	104			23	299	1	2	7	45
Grand Total	13	156			54	702	2	7	9	55

CHANGE OF POSITION OR SALARY OF EMPLOYE

1. If the position of employe is changed or there is a change in the salary, this form should be filled in by the department head and sent to the administrator for approval.

2. Upon approval, the form should be sent to the pay roll clerk.

3. The information should be recorded promptly on the Employe's Record and Employe's Earnings Record.

NOTE: It is important that this form be furnished the pay roll clerk promptly so that the change can be made before the end of the pay roll period affected.

DISCHARGE OR RESIGNATION OF EMPLOYE

1. Upon discharge or resignation of employe, this form should be filled in by the department head and sent to the administrator for approval.

2. Upon approval, the form should be sent to the pay roll clerk.

3. The information should be recorded promptly on the Employe's Record and Employe's Earnings Record.

NOTE: It is important that this form be furnished the pay roll clerk promptly so that the change can be made before the end of the pay roll period affected.

PERSONNEL STATISTICS

Pay roll expense is a large segment of the total operating cost, hence it is important to have a statistical analysis of the pay roll to be used in conjunction with monthly financial reports. Furthermore, the statistical data will aid in computing departmental costs of the hospital.

Following are a number of definitions of the terms used in the form, Personnel Statistics.

DEFINITIONS

PRODUCTIVE HOURS: Productive Hours are actual hours worked. Thus, if an employe works from 8 a.m. to 5 p.m. with one hour off for lunch, the number of productive hours per day is 8. If the number of productive hours per day varies in different departments, we suggest that a schedule be prepared showing the productive hours in the various departments and attached to the schedule of Personnel Statistics.

OVERTIME: Overtime, whether or not paid for, should be included in productive time.

NONPRODUCTIVE TIME: Nonproductive time is time not worked by employe but paid for by hospital; for example, paid vacation, paid sick leave.

FULL-TIME EMPLOYE: One who is engaged to work the required normal number of hours applicable to the department.

PART-TIME EMPLOYE: One who is engaged to work less than the required normal number of hours applicable to the department.

PART-TIME DAYS: To compute part-time days, divide the number of hours worked by all the part-time employes in the department by the normal number of productive hours per day applicable to the department.

STUDENT NURSES: Only the time actually devoted by students to rendering services to patients should be computed and recorded on the form.

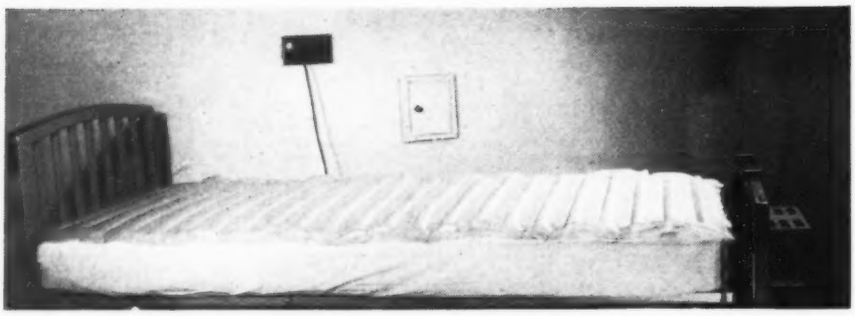

Figure 1: In this photograph, for the sake of clarity, one system of air cells is completely deflated. In actual use complete deflation does not occur. The motor and pump are contained in the cabinet at foot of bed.

Alternating Pressure Alleviates Bedsores

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BEDSORES result from death of tissues owing to inadequate nutrition. The most important factor responsible for the inadequate nutrition is slowing or arrest of the capillary circulation resulting from compression of the blood vessels between the patient's bony prominences and the mattress. This occurs more readily if the blood pressure is low or if the patient's weight is concentrated in small areas because of a lack of cushioning subcutaneous tissue.

A second important factor responsible for inadequate nutrition is poor quality of the blood being brought to the tissues. This poor quality of the circulating blood may be due to a reduction in its oxygen carrying capacity when there is low hemoglobin content or low oxygen saturation from any cause. It may be due to reduction of other nutritive elements in the blood, namely protein, glucose or inorganic salts. Circulating toxins and bacterial infection are among other possible factors.

A third important element responsible for inadequate nutrition is increased metabolic demands by the tissues resulting from fever, from local inflammation or from trauma. The last may be either mechanical or chemical, particularly contact with decomposing urine.

A fourth factor, as pointed out by Munro[1] in cases of spinal cord injury, is loss of the local cutaneous vascular reflexes.

[1]Munro, D.: Care of Back Following Spinal Cord Injuries; Consideration of Bedsores. New England J. Med. **223**:391-398 (Sept. 12) 1940.

It is obvious that bedsores will not develop in tissues that are adequately perfused by blood of good quality. Also, it is clear that tissues which are already sick because of loss of the cutaneous vascular reflexes or because they are receiving inadequate nourishment will die in a shorter time when the blood is interfered with by pressure. In a patient, therefore, with increasing cachexia, the length of time which the tissues will survive a given amount of pressure progressively shortens. In other words, the sicker the patient the more often he must be turned in order to avoid bedsores.

Inasmuch as the benefit that is obtained by turning the patient is a redistribution of the pressure points, and since the prevailing shortage of nurses sometimes prevents this from being carried out, an effort was made to develop a mattress which would effect a frequent redistribution of the pressure points automatically.

The apparatus consists of an air mattress with air cells 1¼ inches in diameter running transversely the width of the mattress. These two systems of interdigitating air cells are then alternately inflated and deflated at intervals of two to three minutes so that the patient's body is alternately resting on the odd-numbered cells and then on the even-numbered cells; this produces a massaging effect which aids the cutaneous circulation.

The alternate inflation and deflation of the two systems are accomplished by means of a tiny air pump which is driven by a small electric motor. This motor develops 1/150 horse power, runs quietly and is connected to a system of valves which automatically shift the air first into one system and then into the other. By experimenting with the speed of the cycle and the amount of pressure, it has been found that the most satisfactory rate is a two to three minute cycle at a pressure of 1 pound or approximately 50 mm. of mercury.

The alternating pressure mattress is constructed of a flexible waterproof plastic material. It is placed on top of an ordinary mattress (see figure 1) and then the bed is made up as usual except that since the mattress is waterproof it does not need to be protected by a rubber sheet and is easily washed after each patient's use. The mattress is well tolerated; most patients rather enjoy the sensation of movements beneath them. It produces no friction of the skin, but merely a gentle compression and release. The alternating pressure mattress has been in use in the Cleveland Clinic Hospital since July 1947.

Thirteen patients whose condition predisposed them to bedsores were placed on the mattress. Six of these had paraplegia and five had metastatic or traumatic spinal lesions with partial or no paralysis. One had had an osteotomy for fracture of the hip and one patient was in a state of severe malnutrition owing to regional enteritis. Five of these patients weighed 100 pounds or less. Three of them could not be turned off their backs because of the traction employed for the treatment of their fractures.

One patient with complete paraplegia was turned only twice a day

because of the extreme pain caused by movement. The other nine patients were turned only every four to five hours. In none of these patients was maintenance of a dry bed a serious problem from the nursing standpoint. No additional precautions were taken to prevent pressure sores and none developed. These patients were on the mattress from five to sixty-three days, averaging twenty-three days per patient. All patients stated that they derived comfort from the mattress.

The alernating pressure mattress has been used for thirteen patients with already developed bedsores. In six of these cases, the decubiti were of long standing and in each case improvement in the appearance of the ulcer occurred which was attributed to the use of the mattress. However, none of the patients was kept in the hospital until healing was complete. One case was a patient with a sacral decubitus 5 by 7 inches in size, decubiti on both heels approximately 3 inches in diameter, and decubiti on both shins approximately 2½ inches in length.

This patient was in poor general condition owing to uncontrolled diabetes and arteriosclerosis. The patient perspired excessively and maintaining a dry bed was a major problem in nursing care. She was turned every three to four hours and kept off her back as much as possible to encourage healing of the sacral decubitus which had been covered by skin grafts. The other areas were cleansed twice daily and a sterile dressing was applied. After thirty days on the mattress the ulcers on the shins were healed and the heel decubiti had decreased in size to approximately 1½ inches in diameter. No further pressure areas had appeared at the time.

A patient with paraplegia in flexion caused by cord compression had decubiti on each hip 4½ inches in diameter when placed on the alternating pressure mattress. The decubiti were cleansed daily and sulfathiazole powder was applied. He was turned infrequently and was given no other therapy except iron for anemia. Within fifteen days the decubiti had decreased to 3 inches in diameter. At this point the patient was transferred with the mattress to another hospital nearer his home.

Of the seven patients with recently developed decubiti, three had extensive cancer and small pressure sores over the sacral area. Two died within five days without any appreciable change in the appearance of the decubiti. The third spent seven days on the mattress and the decubitus showed definite areas of good granulation tissue when the patient expired.

One patient with severe ulcerative colitis and peritonitis, after fourteen days on the mattress, died without any change in the appearance of the sacral decubitus. This patient had involuntary micturition and the bed was almost constantly wet with urine. It was felt that without the mattress the decubitus would have increased in size.

The remaining three patients were diagnosed as chronic arthritis with uremia, chronic glomerulonephritis, and exfoliative dermatitis. All these patients showed improvement in the appearance of the decubiti within one week after being placed on the mattress and two of them were discharged from the hospital in two weeks with the decubiti healed. The local treatment consisted of daily cleansing of the decubitus followed by the application of tincture of benzoin.

None of the thirteen patients having decubiti could turn himself and their position was turned only every three to four hours. The physical condition of all these patients was generally poor. The patients stated that they received comfort from the air mattress whenever they were in a condition to comment rationally.

Records Briefed for Preservation

CLOSE behind the chief record room problem of getting charts completed for filing is the problem of locating adequate space in which to keep them. In the course of a visit to the Jefferson Hospital during the 1946 convention of record librarians in Philadelphia, Mrs. Nellie McBerty mentioned discarding T and A charts to create space. This idea we applied at Children's Hospital, Pittsburgh, to our 16-year age limit which creates, per se, an annual inactive file. After we were well under way with this adaptation, there appeared in the August 1946 issue of *Hospitals* an article which we felt justified this drastic action.

Before the first record was destroyed, a discussion with chief of staff, superintendent and pathologist brought out the following facts which influenced their approval of the decision to dispose of excess paper:

1. The records contained little of value to research.

2. Having gone through a fire and years of deterioration, the legibility and paper texture made poor material for microfilming.

3. The cost of microfilming seemed prohibitive for preserving records of so little value.

4. All records predated A.C.S. Minimum Standards, with no physician's signature on the hospital or operation record.

5. Legally, all patients are now adult plus two years, the legal requirement for entry of suit after attaining 21 years of age.

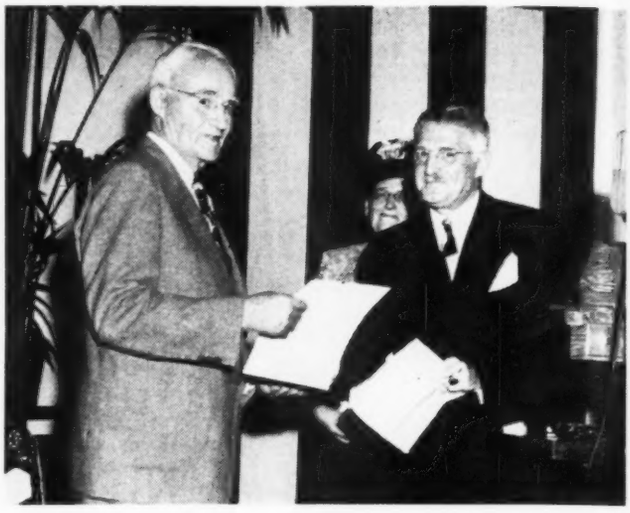
6. Uses made of these old records were shown to be: (a) efforts to establish age for birth certificates; (b) during war years, record of operation and diagnosis for man or woman in service, and (c) rare inquiries for our record in case of adult condition thought to reflect influence of childhood illness.

By copying a minimum of essential data the paper bulk was destroyed on old records from 1892 through 1926; we retained a sample record for posterity as comparison with today's minimum standard chart. All that remains of 19,000 records is one 8½ by 11 inch bound volume, 2 inches thick, listing patient's name and admission number followed by numerical listing, diagnosis, operation, x-ray verification, death, physician's name, admission and discharge date. These records predate complete alphabetization, loose-leaf books and card filing system.

Typing for the volume was done in the record room in a twelve-month period by two registered record librarians who fitted this work into their busy schedule.—MARGARET PAST, *record librarian, Children's Hospital, Pittsburgh.*

PEOPLE IN PICTURES

Above: Accountant Paul Dickes (left) explains survey being conducted in Philadelphia hospitals to Charles J. Seltzer Jr. (center) and Paul R. Hawley, chief executive of the Blue Cross-Blue Shield Commission.



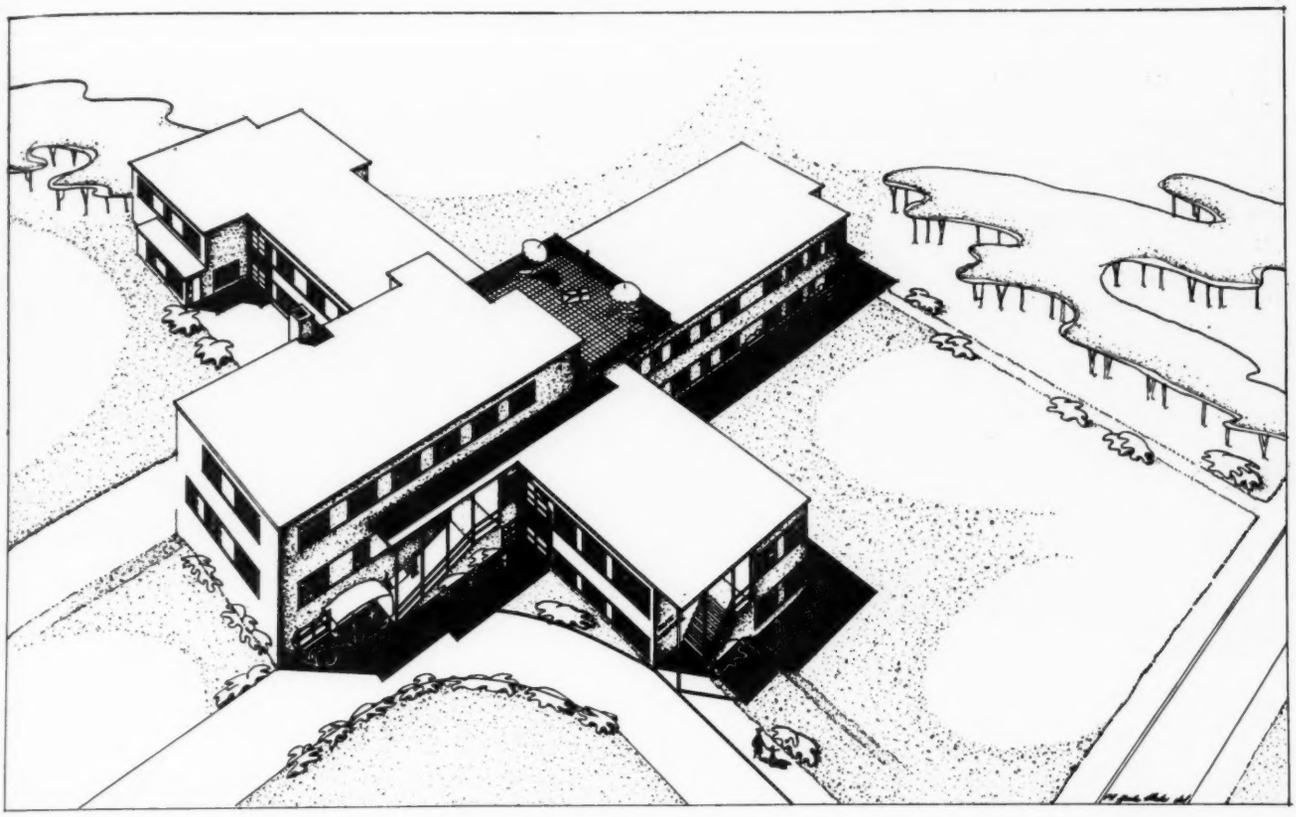
Dr. Harley A. Haynes, former director of the University Hospital, Ann Arbor, Mich., receives an honorary fellowship in the American College of Hospital Administrators, presented by President Edgar Hayhow.

Acme Photograph

At the cornerstone-laying ceremonies of Rose General Hospital, Denver, Dwight D. Eisenhower shakes hands with Mrs. Katy Rose, mother of the late Brig. Gen. Maurice Rose, who was killed in action in Germany. Arnold Rose, the general's brother, stands beside Mrs. Rose.

Ross Porter, assistant administrator of Duke Hospital, Durham, N.C., discusses program notes with James McKelvey Jr. of Grafton City Hospital, Grafton, W.V., (standing) and Thomas Sharpnack, administrator of Broadlawns Polk County Public Hospitals in Des Moines, Iowa.

CONVENTION ECHOES: Left: George Bugbee opens the first house of delegates meeting, with Graham Davis, retiring president, seated beside him. Center: Past President John H. Hayes of Lenox Hill Hospital, New York, and Dr. Charles F. Wilinsky, Beth Israel Hospital, Boston. Right: Sister Mary Reginald, Mount Mercy Hospital and Sanitarium, Dyer, Ind., and Kenneth Williamson, A.H.A.



NOTES ON A SMALL HOSPITAL PLAN

H. GORDON HUGHES
Chief
Hospital Design Division
Department of National Health
and Welfare
Ottawa, Ont.

AT THE request of the provinces, the federal Department of National Health and Welfare in Ottawa inaugurated a division of hospital design shortly after the end of World War II. The object of this division is to act as a consultant and to advise the provinces on the planning of various types of hospitals, producing particular solutions when necessary. This division also acts as a clearing house for the latest information on hospital planning through the collection, tabulation and distribution of material to those who may require it.

Since its inception a great variety of problems relating to the planning of hospitals, large and small, has been brought to the division, both by governments and by private architects.

Because of the large rural population of Canada, the small hospital is of vital importance, and, like the U.S.A., it is in these rural areas that there is the greatest hospital bed shortage at present. To assist hospital boards, physicians and architects and all those interested in the provision of rural hospital beds, the Hospital Design Division has produced schematic plans of the small hospital and rural health units.

Financing Problems

In planning the small hospital, the architect is constantly faced with the problem of reconciling the need for economy with the provision of the services necessary for efficient operation. It must be borne in mind that economy of construction and economy of maintenance and operation cannot be divorced from each other. When the problem of initial fund raising for construction is uppermost in people's minds, it is often difficult to face the all-important question of operating and maintenance costs. The late Dr. Goldwater aptly stated the case when he said that, "Economy in hospital construction includes economy in production and economy in use. It is a mistake to consider building cost apart from maintenance cost."

Planning

Although particular requirements, orientation, ground contours, and the site generally should determine the actual shape of a building, the cruciform plan for the small hospital has advantages that warrant consideration. This plan divides medical and surgical patients from the maternity wing, and

both wards are capable of expansion. The operating suite is in a separate wing, as are also the administrative offices.

The cruciform plan makes it possible for one night nurse to control the whole hospital from the central nursing station, with possibly a ward aide for each ward. The large areas of exterior wall may cause some concern, especially in the colder parts of America, but the economy of operation made possible by having patients on one floor is believed to have real advantages.

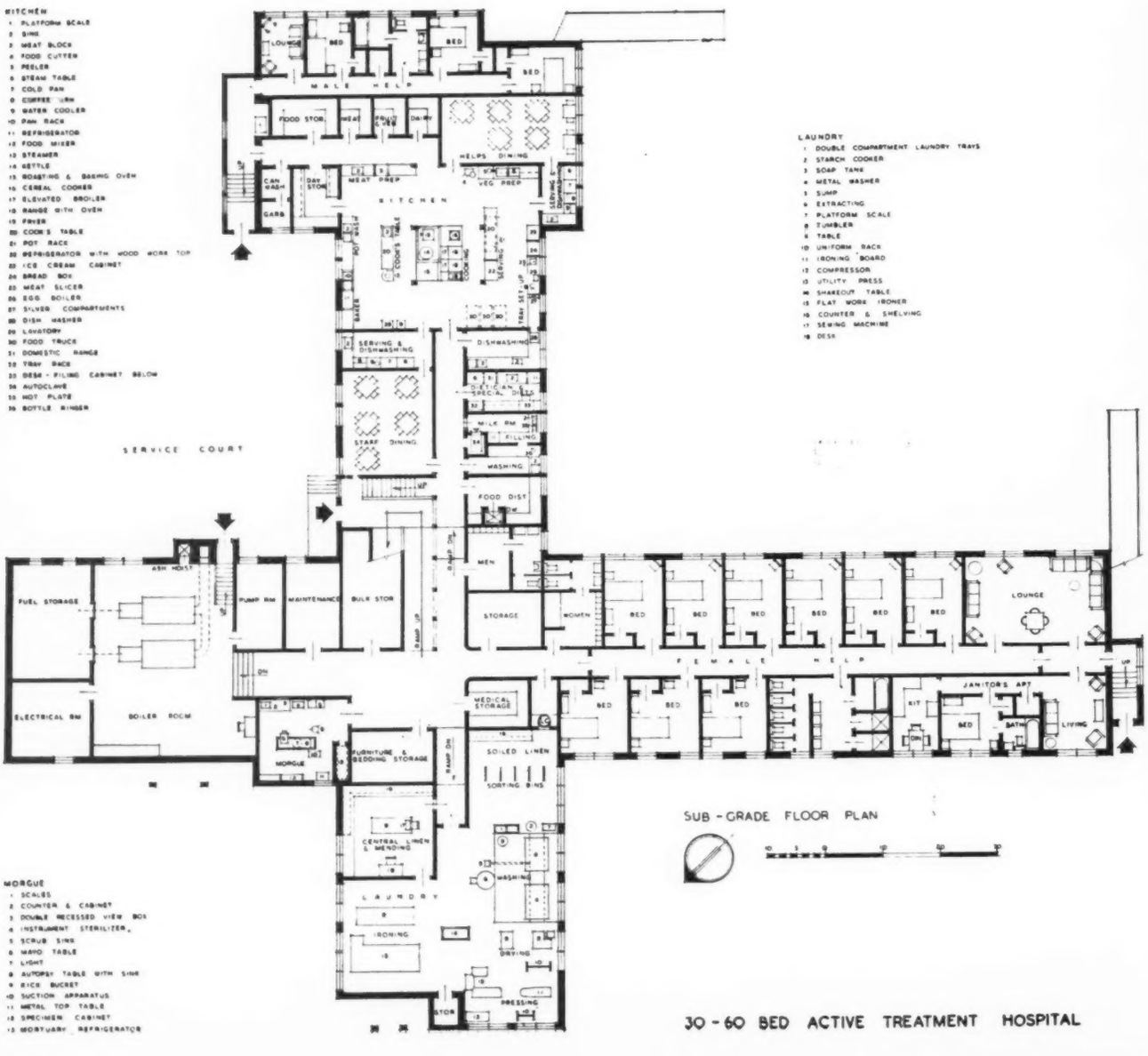
Subgrade Area

In most parts of Canada foundations are required by frost conditions to be 4 feet 6 inches below grade. This would mean that the subgrade finished floor would be approximately 3 feet below grade. The excavation so formed would be the cheapest cubic area of the building. The main floor should be sufficiently high above grade to allow generous windows in the subgrade area. Additional headroom is obtained in the boiler room, laundry and kitchen areas by means of ramps or steps down. It is suggested that hospital employes could have rooms in this area as well. However, this portion could be left unfinished if it was not required. Similarly, the laundry could be omitted if this work was done outside the hospital, with the area being used for additional storage space, which never seems to be adequate for any hospital.

A ramp in place of an elevator in a one-story building is proposed because the rural hospital may be far removed from elevator maintenance, and a breakdown of vertical traffic would cause considerable inconvenience. Also worth consideration is the possible saving in initial cost of construction. In these plans the ramp is located close to all main storage areas, a valuable step saver for the staff members.

Main Floor

There are one or two items of the plan that might be noted which tend to facilitate the economical operation of the hospital: first, the use of an observation room, which would be used in cases of shock, mental or noisy patients. It is adjacent to the ambulance entrance and the operating suite. Such a room would obviate disturbance in the wards, especially at night. The use



of one ward pantry for both wards saves space and equipment. A spare ward equipment room is a means of keeping odd pieces of equipment out of the hospital corridors.

Local requirements will determine whether doctors' offices and examining rooms will be incorporated as part of the hospital plan. Serious consideration should also be given to the inclusion of a medical library where the hospital board might hold its meetings.

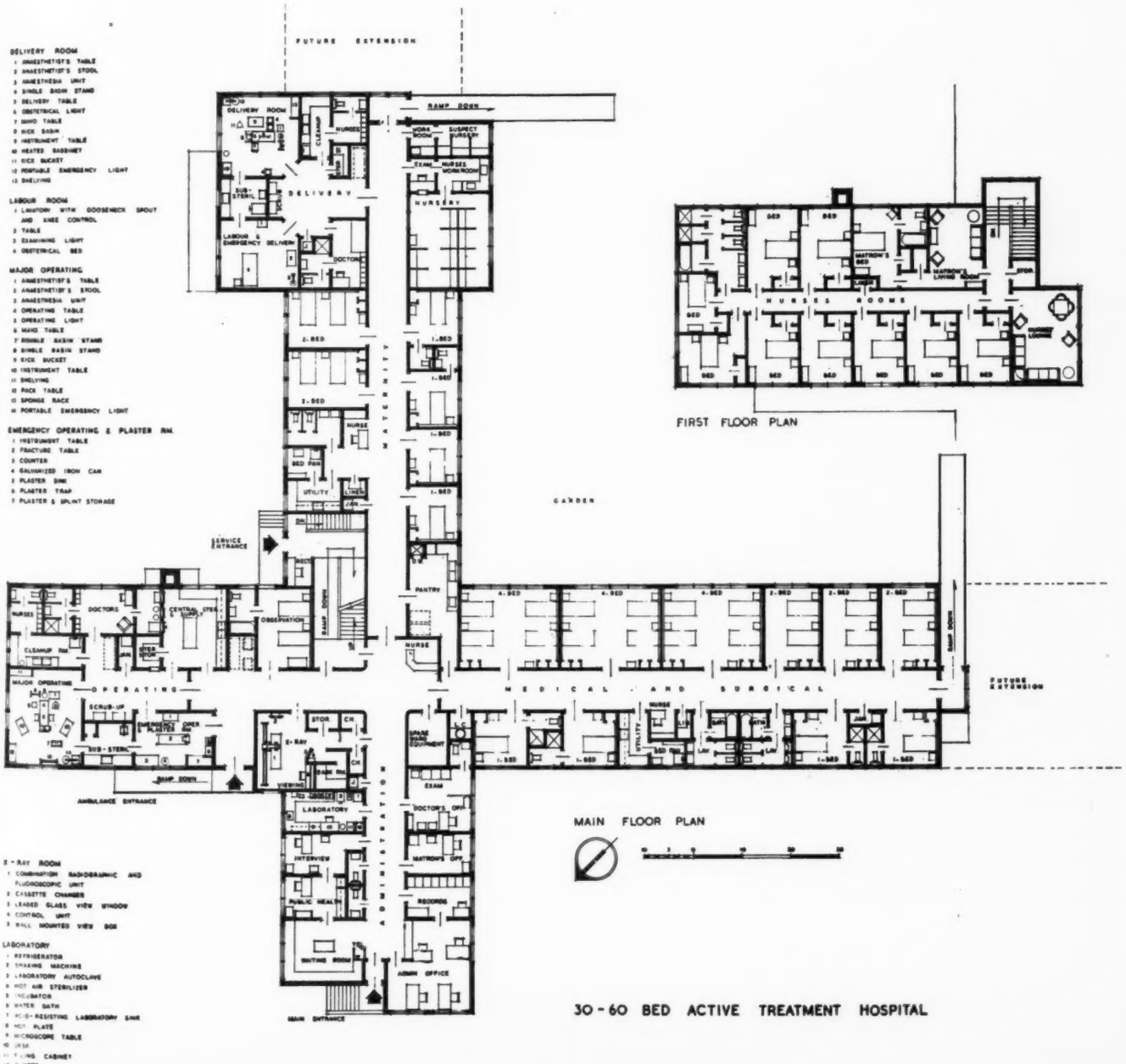
Ramps from the wards to grade permit quick and easy exit of patients in case of fire and also allow patients, who may be in hospital for longer than average stay, the advantage of convalescence among pleasant surroundings.

Nurses' Accommodation

The suggestion of including nurses' quarters as part of the hospital has met much criticism. But with housing at present so hard to find, it is often difficult for nurses to board out, and although it is admittedly more satisfactory for a hospital to have its own nurses' home separate from the hospital building, the smaller communities cannot always afford this, especially when they are faced with the costs of constructing, equipping and staffing a new hospital building.

It has, therefore, been suggested that the nursing staff be housed over the operating wing or the administrative wing where there is less likelihood of any noise disturbing either the patients or the nurses. In the small hospital this location has one additional advantage, *i.e.* that nurses are within easy call in case of an emergency. On the other hand, such a situation is not so pleasant for the nurses, particularly the senior ones, who may be disturbed unnecessarily.

In conclusion it should be noted that the plans produced by this division are schematic only and that much of the thinking behind them has been to a large measure tempered by the excellent plans and literature published by the Division of Hospital Facilities of the United States Public Health Service, Washington, D.C.



30 - 60 BED ACTIVE TREATMENT HOSPITAL

CONSULTATION AT NO COST

Under Nebraska's Voluntary Consultation Plan veteran administrators help the less experienced with their hospital planning problems

JAMES G. CARR Jr.
Fiscal and Personnel Director, University of Nebraska, Omaha

PERHAPS, the equipment and supply problem can be classed as the most difficult situation facing today's freshman trustee. There are so many items of which he has never heard or, at least, of which he has little knowledge. Planning the physical structure seems almost simple compared to the planning of equipment requirements. Even the veteran administrator recognizes that the job of equipping a new hospital is a major task. The novice finds himself confronted with an insurmountable barrier of technical confusion.

Every section of the country is engaging in hospital expansion programs. The public has become hospital-conscious, and communities in even the lowest population bracket are planning units of their own. The rush is on; the need is evident; the end result of it all is the yet unanswered question: Will these new projects be efficient, well equipped hospitals or will they suffer from haste and lack of knowledge on the part of well meaning but inexperienced trustees?

SO MANY THINGS ARE NEEDED

It takes a variety of things to build a good hospital. Money, and in these days lots of it, is obviously a vital necessity. Public support and hard work of at least several citizens are basic. Sound counsel must be obtained from a competent architect or a consultant with previous hospital experience in regard to construction problems, and when the building is completed, the important problem of obtaining proper equipment must be solved to assure good care of the patients.

Much assistance is obtained from the many competent and helpful salesmen who find their way to the new hospital's door. They bring advice, and their catalogs and pamphlets have illustrations and ample descriptions of many items. The salesmen should surely be made welcome for they will offer a multitude of worth-while suggestions.

There is still much essential information missing despite catalogs, pamphlets and sales talk. In many cases there just isn't enough money available with which to purchase all of the items that are declared to be essential. Some purchases must be eliminated, others must be scaled down in price. The process of selecting quantities and qualities, sizes and models, and of eliminating the least needed items seems to call for the advice of someone well acquainted with the problem.

Early this year, several members of the Nebraska Hospital Assembly recognized this need of new hospital officials being adequately informed on the subject of equipment and supplies. It was evident that small units could not afford the cost of high priced consultation service and, therefore, a plan was devised to provide a measure of consultant service at no cost to the hospital.

E. C. McDade, president of the Nebraska Hospital Assembly, appointed a hospital consultation committee consisting of Eugene Saxton, superintendent, Dodge County Community Hospital, Fremont; Harold Hamilton, administrator, Brewster Hospital, Holdrege; Cecilia Meister, administrator, York General Hospital, York; Richard C. Wiebe, business manager, Mennonite Deaconess Hospitals and Homes, Beatrice, and James Carr, assistant administrator, University of Nebraska Hospital in Omaha.

This committee met early in May and agreed to offer its services to assist in the problem. Meeting with the committee were Verne A. Pangborn, director of the division of hospitals of the State Health Department, several representatives of the U.S. Public Health Service, and several hospital administrators from hospitals in Lincoln and Omaha.

It was decided that the consultation service would generally involve visits to the hospitals of committee members. Detailed advice and opinions would be given during the course of a tour of the hospital. Thus, on-the-scene answers could be obtained by the visitors. The voluntary consultation service would not be limited to committee members, but rather all Nebraska Hospital Assembly members would be encouraged to provide assistance whenever it was desired.

How is this effort to lessen the technical confusion working? Apparently, very well! Evidence that it is a desired service was provided by one committee member who announced that he had conducted thirty-six different groups through his hospital prior to the formation of the consulting committee. Since then, he has had a number of additional groups tour his institution. In several cases individual trustees have visited various Omaha hospitals in their search for information.

REFERRED TO COMMITTEE MEMBER

The State Health Department now answers each letter of inquiry regarding supply and equipment problems by referring the writer to the committee member nearest his locality. Plans can then be made for a tour of the hospital and for consultation with the administrator.

The success of the current hospital expansion program depends upon the quality of hospital that is produced. If well constructed, well equipped hospitals are the end result of this vast program, then all hospitals will profit. If, instead, poorly built and equipped hospitals come on the scene, the public may well lose interest and enthusiasm. It is vital that these new units be good ones, and every veteran administrator and trustee should do everything possible to encourage and assist toward the success of the new hospital.

Nebraska's voluntary consultation plan doesn't ensure success of the new institution, but it should go far in the fight against failure. The problem is evident; the solution is in large part in the hands of the experienced, and their helpful assistance should be always available.

THERE IS NO COMPARISON OF COSTS

Without Uniform Accounting Procedures

LOUIS BLOCK, Dr.P.H.
Acting Chief
Office of Health Services
Division of Hospital Facilities
Public Health Service

THERE is a definite need for good accounting in hospitals today as a vital tool for efficient and proper administration.

The financial factors involved in any operation make it necessary for the administration department of an institution to justify the operation. A continuous and comprehensive review of all aspects of an operation is necessary in order to achieve and maintain an efficient administration. Comparisons with other operations become a measuring device in any review and unless there is uniformity of the basic structure in the presentation of that operation throughout all like institutions, such comparison is not possible.

A.H.A. RECOGNIZED NEED

In 1935 the committee on accounting and statistics of the American Hospital Association in its publication "Hospital Accounting and Statistics" recognized the need for combining uniformity of principle with flexibility of application in establishing hospital accounting records. The application of good procedures, unless accompanied by uniformity of principle, takes care of only one aspect of need. Uniformity of principle, whether reflected by a standard statement of account classifications or through a standardized system of accounting, is a definite need to permit the comparison of activities between two institutions, in a group of institutions, or among all institutions.

This uniformity is not confined merely to the statement of the accounts themselves; it must also be included in the hospital's statistical reporting of services rendered. This is vital to a comparison of services and items of income and expense and, furthermore, should mean the same thing to one institution as to another.

Presented at the annual conference of the Arkansas Hospital Association, Little Rock, Ark., 1948.

It is evident, therefore, that interest in standardized accounting is a reflection of the need for standardized reporting and standardized content of the items included in the report. As far back as 1935, it was recognized that such items as cost per patient day did not mean much in comparing costs between institutions, unless in the institutions being compared, costs included the same items, and patient days included a similarity of technic of counting.

In more detail, what is meant by cost is the total content of the expenditures. It has been shown that some institutions include only the operating expenses as the basis for arriving at costs. Others include auxiliary service expenditures, such as taxes and interest, others exclude depreciation. For this reason, without uniformity of content and the meaning of cost there could be no reliability in comparing per patient day costs of one institution with those of another. A similar situation occurs with the count of patient days of care. Some institutions include infant days, some institutions weight infant days as portions of an adult day, and others exclude the count of infant days.

Another factor that weighs heavily on the accuracy and usability of data for comparable purposes is the lack of a uniform period of time for reporting. In a static situation, where there is no basic change in salaries, personnel or cost of supplies and equipment, such a difference in time of reporting does not constitute too serious a problem. However, in days of rapidly fluctuating pay rolls and costs, differences in periods of time for reporting may appreciably affect the cost arrived at.

Uniformity of reporting was endorsed as far back as the thirties. We have not accomplished nor are we anywhere near that necessary goal. With the advent of Blue Cross and government programs, such as veterans', Emergency Maternal and Infant Care, Vocational Rehabilitation and others, the need for more information regarding the hospitals' operation on a standard interpretative basis became imperative. Inasmuch as these agencies purchase care on the basis of cost, it is evident that uniformity of accounting and reporting becomes a "must" rather than merely desirable.

MEAN SAME TO ALL

The problems involved in the development of the "Government Hospital Reimbursable Cost Formula," Joint Hospital Form No. 1, would not have arisen if uniform accounting and reporting had been instituted when it was first advocated. The interests of groups representing both the hospitals and the agencies that are paying for care in arriving at an equitable basis for reimbursement are further evidenced in a need that has been expressed time and time again but as yet has not been fulfilled. Perhaps that is just the sort of pressure that is necessary to make hospitals generally conscious of the need not only for having good accounting records but also for arranging those records in such a fashion that when reports are issued they mean the same thing to all.

Efficient use of funds completely to carry out our basic responsibility of adequate medical care at the lowest possible cost to the patient requires that we become fully aware of each aspect of the hospital's operation. As a result, we have come to appreciate the need not only for adequate accounting but also for uniformity of reporting throughout all like institutions.

One of the best means of presenting the need for uniformity is through specific examples of existing figures which defy any possibility of reliable comparison.

ADMINISTRATION DEPARTMENT

An analysis of several nonprofit hospitals shows that administrative expenses ranged from $0.23 per patient day to $2.38 for hospitals under fifty beds in size. The fact that one hospital can operate administratively for as little as $0.23 per patient day raises the question as to whether or not this particular institution reported even the bare necessities of true administrative expenses. In part III of the American Hospital Association's "Manual on Hospital Accounting and Statistics" is given a list of bona fide expenses charged to the account for administration. How is it possible for a hospital to have an average daily patient cost of $0.23 for administration?

Under the caption of salaries in this accounting textbook are listed the following items: superintendent, assistant superintendent, telephone operator, stenographers, information clerks. Large hospitals also employ accountants, bookkeepers, credit men, collection personnel, purchasing agents and clerks, admitting officers and clerks, storeroom clerks, a general librarian, and a hostess.

It would be reasonable to assume that a small hospital does not employ all the personnel mentioned. However, it is reasonable to assume that a fifty-bed hospital would employ an administrator, at least two telephone operators, who would have other responsibilities, such as information, and a bookkeeper or an accountant. In addition, it would in all probability have a storeroom clerk, who might have the combined responsibilities of ordering, storing and issuing supplies and equipment. Summarizing the foregoing personnel, estimate of cost is as follows:

	Per Year
1 superintendent	$3600
2 telephone operators @ $1500 each	3000
1 bookkeeper	2000
1 storeroom clerk	2400
Total	$11,000

How about postage, stationery, business forms, bookkeeping ledgers, purchasing forms, storeroom forms, general library books? For discussion purposes, it is assumed that this particular hospital was thrifty and could get by on $500 a year for these items. Finally, there are miscellaneous expenses that usually cannot be distributed directly to other departments. They are telephone services, telegrams, legal service, association dues, advertising, depreciation of equipment, public auditing, insurance of all kinds, and traveling. In a year's time the cost of such items may amount to $3500. The overall summary of the administrative department would be as follows:

Salaries	$11,000
Supplies	500
Miscellaneous	3,500
Total administrative expenses	$15,000

Using the patient days of care reported by this institution, an average patient day cost of $0.77 is computed for administrative expenses instead of the $0.23 reported.

In analyzing such costs, what did the first hospital leave out of its report on administrative expenses? Did it include only the cost of supplies and miscellaneous expenses and charge the salaries to other departments? With the high cost of personnel and the increased cost of administrative supplies it is difficult to understand, without making a detailed audit of expenditures, just how the activities of this hospital could be conducted on such a small average daily cost.

On the other hand, a hospital reporting $2.38 per patient per day may have included other operating expenses as part of its administrative expenses. This institution may have charged to administration the cost of motor service, taxes, medical records and library expenses, social service, and other items. The only conclusion that can be arrived at in an attempt to compare the administrative expenses of Hospital A with those of Hospital B is that these costs cannot be compared.

DIETARY DEPARTMENT

An analysis of the cost of the dietary department shows a range from $0.87 per patient day to $4.52.

Dr. Malcolm T. MacEachern's "Hospital Organization and Management," and hospital experience show that average dietary cost is from 20 to 25 per cent of the hospital's expense. Using an average of 22½ per cent, it would be noted that an institution having a rate of $0.87 per patient day for dietary direct expenses would approximate $3.80 as the total cost per patient day. For an institution with an expenditure of $4.52 per patient day for dietary expenses, the average cost per patient day would be $22.

If these per patient day figures were translated into terms of annual number of patient days of care, the total estimated expenses arrived at fall below the actual amount reported for the hospital reporting a dietary cost of $0.87 and far above that which was actually reported in terms of dollars and cents for the hospital reporting such costs of $4.52. So, here again, the figures as presented are not comparable. Only a complete audit of the account expenditures would permit a proper comparison between the dietary costs of Hospitals A and B.

NURSING SERVICE AND NURSING EDUCATION

The American Hospital Association's accounting manual lists the content of this account title. The salaries and allowances paid to the director of nurses, assistants, supervisors, all nurses (graduate and student), nursing attendants, orderlies, except those employed in the library or in special services for which special accounts are maintained, should all be charged to the account of "Nursing Service and Nursing Education." It is also noted that when nurses serve in other capacities, such as record librarian, technician, social worker, or admitting clerk, their salaries should be apportioned to the time spent in these activities.

The supplies charged to this account include uniforms, textbooks, school supplies, and other items. Under miscellaneous charges, it is stated that allowances for nurses' maintenance, other than in the nurses' home, are a legitimate expense to this account. For graduate nurses, such allowances may be paid regularly in cash, in which case they may be recorded as "salaries."

The items to be charged to "Nursing Service and Nursing Education" have been quite clearly defined. It should not be too difficult to make an equitable distribution of the direct expenses involved. In the hospital reports examined, the cost per patient day for this service ranged from $0.05 to $4.60. This low of $0.05 appeared in the records of a hospital having a 100 bed capacity. How much nursing care could a patient receive for a buffalo nickel?

Just imagine a hospital of that size giving nursing service to a patient for a twenty-four-hour period for a prewar price of a cup of coffee. This obviously is a physical impossibility, yet that is what the financial report showed. It is without a doubt the result of faulty classification or improper coding of expenditure. With nursing service costs approximately 20 per cent of the hospital's per patient day cost, the total cost of operation of $0.25 per patient day would be desirable if adequate care could, by any stretch of the imagination, be given for so small a sum.

This kind of analysis could be carried on for other hospital departments. Variations and wide ranges in departmental direct cost distributions would be the result. It is generally observed that legitimate expenses that have been incurred by a particular department may and probably are included with certain unrelated items in the hospital's individual system of accounting.

The accompanying table presents the proportionate distribution of hospital expenses by departments based on the study of a limited number of hospital reports.

With adequate accounting records based on the principle of uniformity the institution has an excellent basis from which to build its springboard of detailed hospital cost accounting. This is a long step toward better hospital financial reporting. It has always been necessary but is now at long last becoming a reality.

Average Dollar of Expenditure in General Nonprofit Hospitals, 1946-1947*

Department	Total	Under 50 Beds	50 to 99 Beds	100 to 199 Beds	250 and Over Beds
Administration	$0.09	$0.10	$0.09	$0.08	$0.08
Dietary	0.20	0.19	0.20	0.21	0.20
House and property	0.20	0.18	0.20	0.20	0.20
Medical and surgical	0.10	0.11	0.10	0.10	0.10
Nursing	0.22	0.28	0.25	0.22	0.21
Other professional services	0.14	0.09	0.12	0.14	0.15
Other miscellaneous services	0.05	0.05	0.04	0.05	0.06
	$1.00	$1.00	$1.00	$1.00	$1.00

* Based on analysis of a limited number of hospital reports.

WE CANNOT MAKE DISTINCTIONS

Between "Chronic" and "Acute"

1. Because medical progress at this stage of its scientific development can no longer recognize any artificial line of demarcation between the two.

2. Because social progress never recognized any such line of demarcation and did, indeed, set integration as a goal which is now in easier reach than ever before.

3. Because the laboratory in the modern hospital is at last coming into its own, to do for the "chronic" patient what medical science, with the help of nature, has almost always done for the "acute" patient. ("God helps those who help themselves.")

4. Because we cannot stultify ourselves as teachers by denying the ultimate value of the chronic patient in a policy of integration. ("Sweet are the uses of adversity.")

5. Because we are beginning to recognize the value of the continuous, unhurried and tenacious characteristics of full-time medical service in hospitals.

6. Because the most challenging problems in hospitals are the "chronic" unsolved problems.

7. Because we are living longer than ever before and mean to live more comfortably during those later periods in our lives when we are most susceptible to "chronic" illness.

8. Because voluntary hospitals are being deprived of a major excuse for the premature transfer, segregation and isolation of "chronic" patients, *i.e.* lack of money for their care. Government, voluntary self-help insurance plans, and greater philanthropic insight are working in favor of the principle of integration.

9. Because there are not enough "acute" patients to fill all "acute" general hospital beds in this age of chemotherapy and the antibiotics. We are discovering gradually that we have beds for those who may need them whether they are "acute" or "chronic."

10. Because we have had demonstrated to us that the hospital can inexpensively conduct a successful extramural home-care program on an extension basis for those patients, "acute" or "chronic," who do not require an expensive hospital bed.

11. Because of growing patient pressure.

12. Because of the desire of the "acute" general hospital to avoid being shown up for mistakes in diagnosis and therapy, which often appear after the premature transfer of unsolved medical problems.—E. M. BLUESTONE, M.D.

THE "49TH" STATE IS HEALTHY

CARL I. FLATH
Administrator
The Queen's Hospital, Honolulu, T.H.

One of Hawaii's modern hospitals.

WHAT about Hawaii's health? Is the Union about to inherit a cripple, or a vigorously healthy addition? Hawaii is within an inch of achieving statehood, so it's about time this question was answered.

By whatever yardsticks Hawaii's statehood qualifications have so far been measured, it has stacked up ahead of many of the forty-eight states—and, its health record has outdistanced most of them. Yes, Hawaii is healthy, and its hospitals have played an important rôle in making it so.

Before Captain Cook got around to discovering the Hawaiian Islands in 1778, the highly moral and rugged Hawaiians were doing pretty well for themselves. Such sickness as was then to be found in the scattered islands of the archipelago was cared for by "kahunas" under a healing system of surprising refinement. Physical aches and pains were recognized as disease conditions, in contrast to the capricious spiritual superstitions believed by most primitive peoples. The "kahuna" diagnosed by responses of disease to selected herbs and treated the sick with unusual good sense through diet and physical therapy.

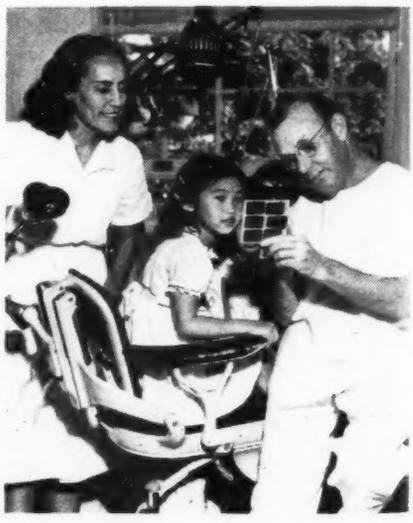
But, with the coming of the white man, history repeated itself and the nature-loving, easy-going Hawaiians were faced with new health problems.

By 1810, tough, powerful King Kamehameha I had "united" the several islands into a single kingdom; missionaries were on the way, and by 1894—when Hawaii was annexed to the United States—"big business" had come and conquered. Nineteen hundred brought Territorial status.

Hawaii's radical and rapid transition in little more than a century from a semiprimitive state to a world center of trade is probably without parallel. Under these circumstances, it might be expected that public health conditions would seriously degenerate. The reverse has been true for, as problems affecting the public welfare have presented themselves, Hawaii's leaders have faced them boldly.

"Our first duty is that of self-preservation," declared desperate Kamehameha to his legislature in 1855. "Our acts are in vain, unless we can stay the wasting hand that is destroying our people," he said. And then, the King himself, with benevolent Queen Emma, went from door to door, collecting money to build the Islands' first public hospital—Queen's Hospital. Sixteen years earlier, before most mainland states had even given thought to the matter, this far-sighted monarch had created a seven-man board of health.

Geography and topography of Hawaii, combined with the admixture of races in Hawaii's 500,000 population, have created problems in public health development of a type not present in a mainland state. In spite of this, its health statistics compare favorably with many, and excel most, mainland records.



Left: Industrial health and safety are highly developed on Hawaii's sugar and pineapple plantations. Right: Children learn at an early age the importance of proper dental treatment.

HOSPITALS

Apart from Honolulu and Hilo, with combined populations representing about one-half of the total, the Territory is largely rural by mainland standards. There is this difference, however. Since the major agricultural enterprises are sugar and pineapple growing, rural populations are not widely scattered, as is true in most rural areas of the mainland. Agricultural workers in the Territory are, as a rule, clustered in the immediate vicinity of plantation (sugar or pineapple) mills.

Serving urban and rural areas are sixty-one hospitals with 5700 beds, for a ratio of 4.7 beds per thousand of population. This ratio is surpassed by only one state—Massachusetts. Forty-five general and allied hospitals (ranging in size from 25 to 450 beds); eight convalescent; ten tuberculosis and mental hospitals, plus a leper colony, combine to give the Territory excellent geographical hospital coverage.

The larger urban hospitals rank with mainland hospitals of like size in every respect. Two have approved schools of nursing, and full accreditation for graduate medical education. As early as 1903, the Queen's Hospital was training interns and residents and, in 1913, established the Territory's first school of nursing. The vast majority of Hawaii's island-born nurses, and more than 80 per cent of its physicians, are "products" of the Queen's Hospital, which, since its founding in 1859 by Queen Emma, has grown from a thirteen-bed hut to a 450 bed modern hospital. A passing reference to hospitalized patient statistics during this period is indicative of the fact that Hawaii's hospitals have kept pace with the most progressive institutions of the mainland. The average length of stay in 1872 was eighty days; in 1905, thirty-four days; in 1925, twelve days, and in 1947, 7.5 days.

RURAL HEALTH

Rural hospital and medical services are excellent under a comprehensive health plan which plantation corporations found it necessary to set up for the thousands of workers imported from the Orient, or transported from urban centers. Until quite recently, such service was an employment perquisite. It has been costly, but health dividends have more than justified the practice. Paternalistic as the system may be, the fact is that, as a group, plantation workers of Hawaii have received as fine health care as have any people anywhere.

Parents are present during physical examinations of school children.

The program is coordinated among all plantations, and the low morbidity and mortality among the beneficiaries of the system stand at the top of similar statistics from anywhere in the world. Unrestricted hospital care, preventive medicine and dispensary service are available for every worker and his family. Visiting nurse service under the plan is also provided by most employers.

This is one of the most interesting chapters of Hawaii's health story.

MEDICAL PRACTICE

Three hundred and eighty licensed physicians are spread over the six major islands of the Territory. All special branches of medicine and surgery are represented, and it is not uncommon to discover that as many as 10 per cent of the doctors are on the mainland at any one time "brushing up" or preparing for specialty boards.

What might well be termed an "in-service" training program is conducted annually, or more often, when mainland specialists are brought down to conduct special courses and lectures under the sponsorship of the Hawaii Territorial Medical Association. Two hundred dentists practicing in the Territory play a major rôle in keeping Hawaii healthy.

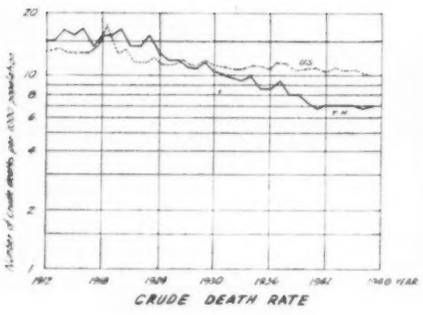
BOARD OF HEALTH

Founded more than a hundred years ago, the Territorial Board of Health is one of the oldest in the country, and, with a biennial budget of $3,000,000 (or almost $3 per capita), is certainly one of the best financed. Quite a public health budget for a population the size of Cincinnati! Customary federal grants-in-aid supplement local appropriations.

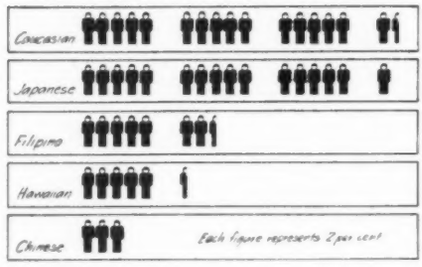
Singularly fortunate over the years in having good administrative direction, the Territorial Board of Health has exerted a tremendous influence on the people of Hawaii. Its citizens of all races readily accept and support the effort of the board of health in establishing good health practices.

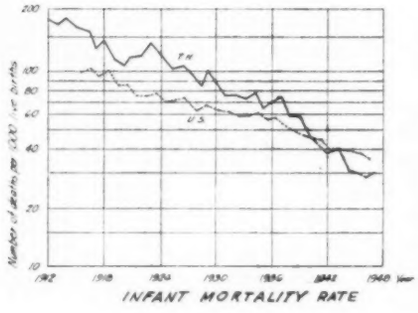
County (island) health departments are headed by full-time health officers, and, in contrast to the officers in many mainland states, the local health officer is directly responsible to the president of the Territorial Board of Health. The department operates through a system of four divisions and seventeen bureaus and laboratories, all under the direction of personnel that has had special preparation in the respective activities.

Industry has cooperated with the board of health to develop a high state of industrial health conditions,

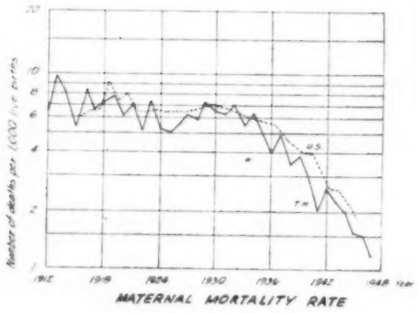


CRUDE DEATH RATE

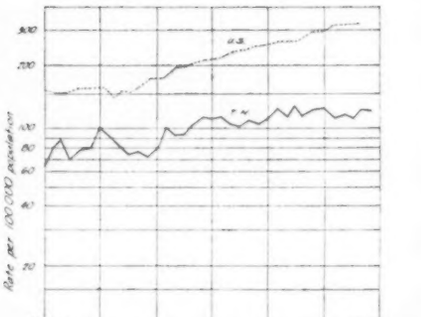




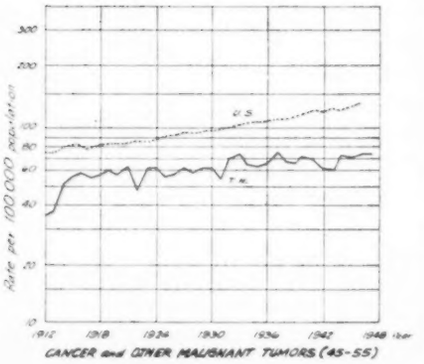
INFANT MORTALITY RATE



MATERNAL MORTALITY RATE



HEART DISEASE (90-95)



CANCER and OTHER MALIGNANT TUMORS (45-55)

under which the environment and well being of workers are protected.

Public health laws and regulations having the effect of law, as well as customary public health services, parallel those of progressive mainland states. Public health nursing through the board of health ranks unusually high, as evidenced by the fact that Hawaii ranks third among the states having the greatest proportion of nurses who have completed accredited courses in public health. The ratio of public health nurses is about one to 5000 people—not ideal, to be true, but far in excess of the mainland as a whole.

Here are a few enlightening comparative statistics (1947):

	Hawaii	*U.S.*
Crude deaths per M population	6	10
Infants deaths per M live births	30.5	32.6
Maternal deaths per M live births	1.6	2.1
Cancer deaths per 100 M population	72.7	134.5
Heart disease deaths per 100 M population	110.8	321.5
*Tuberculosis deaths per 100 M population	36.9	33.2

*Many Japanese consider T. B. social disgrace, making early case finding difficult.

HEALTH EDUCATION

Helping teachers of the public school system to develop strong health programs is a major function of the division of health education of the department of public instruction. Health education workshops are conducted to assist teachers in correlating classroom instruction with the needs of the child and the community. Health posters, pamphlets, films and other materials are in use every day throughout the school system.

Physical examinations and tuberculosis case-finding are two of the important health services in the schools. Twenty-five dental hygienists and assistants clean and examine the teeth of all children in grades one through eight once each year. Toothbrush drills are held and lectures are given on dental health. Only 9 per cent of the rejections under selective service were for dental defects in Hawaii, against 20 per cent for the mainland. Where a full-time nurse is not employed by a school, a public health nurse covers the assignment. Health counselors are appointed by each principal to coordinate the health education and service program in each school.

Among the most potent instruments for the coordination of the educational and service efforts of both public and private health agencies is the Oahu Health Council. Fifty-five agencies concerning themselves with health programs of every type are represented in its membership. Its monthly bulletin, with a circulation of several thousand, is issued to promote general understanding of health programs and health resources.

CHAMBER OF COMMERCE

Bubonic plague quarantined the port of Honolulu in 1900 and emphasized the need of protection against further importation of rat-borne epidemics. Recognizing their responsibility for community health, shippers and importers voluntarily agreed to tax all freight tonnage entering the port. This fund is administered by the Chamber of Commerce through its public health committee and its professionally trained staff. Community surveys, support of the public health nursing program, mosquito control, and school health education are a few of the community programs for which the public health committee has made expenditures as high as $100,000 in a single year.

YES, HAWAII'S HEALTHY

With mild, equable climate free from extremes, with an average temperature of 74° F. and an average range of 9° F. either way, with balmy tradewinds sweeping it, how could Hawaii be anything but healthy! There's more to it than that. These very assets bring public health hazards, which are not always present in less agreeable climates.

The answer lies in more than a century of careful planning and unrelenting coordinated effort on the part of government, the general public and professional people in the direction of prevention or eradication of every controllable threat to public health and well being.

Some Sidelights on

THE NURSING SHORTAGE

ALICE L. PRICE, R.N.

MUCH has been written as to the need for better working conditions for nurses, the need for more pay for nurses, the need for shorter hours for nurses—and in the minds of most lay people, the problem in regard to nursing is a simple and easily understood desire for better environment, more pay, and shorter working hours.

Although these three factors are important and should be given consideration, they are not, and never have been, entirely responsible for nurses being so dissatisfied with nursing that they are turning away from it at a rate which tends to exceed that of new enrollments in nursing schools.

FAULT IS NOT HOUSING

If better working conditions constituted approximately one-third of the underlying cause for the nurse shortage, then many institutions that are equipped with modern facilities and that furnish attractive residences for nurses should be much better staffed than are the smaller, less desirable, less well equipped hospitals. Such is not the case. Large modern hospitals have been forced to close entire departments and limit the number of patients being admitted in exactly the same proportion as have smaller hospitals which cannot offer such attractive living quarters or desirable working conditions.

One can readily see the fallacy of attributing a large part of the discontent of nurses to their environment when a large percentage of nurses find the nurses' residence much more comfortable, more convenient, and more attractive than the home from which they came. For untold numbers of nurses who came from families of laborers, miners and unskilled workers, a nurses' home may furnish their first contact with the American way of life characterized by the term "gracious living."

The other two of the three so-called "major" causes of the critical nurse shortage—long hours and poor pay—do not bear close scrutiny either.

If long hours and inadequate pay were responsible, then we should see an immediate improvement in localities where these undesirable conditions have been corrected. Many hospitals are paying approximately $200 a month for general duty nursing and are paying much more than that for nurses with special training that qualifies them for teaching or supervising.

In some states private duty nurses are earning $10 for eight hours of work. Such salaries, even in this time of high wages and high cost of living, cannot be considered "poor pay." The man of average income of $3000 to $5000 per year pays $30 for the services of a private duty nurse for each twenty-four-hour period and can seldom afford nursing care at that price for longer than a few days.

Although the services of a private duty nurse are required in some illnesses, most nurses will readily admit that in the majority of cases the patient is being greatly overcharged for the actual amount of nursing service rendered.

Many hospitals and other institutions have reduced the work week from forty-eight to forty-four or forty hours per week without the resultant expected increase in the number of nurses who seek employment.

It is my opinion, therefore, that other equally important conditions have a decided bearing on the present nurse shortage.

SOCIAL LIFE IS CRAMPED

It is well known to the general public, for example, that young girls just graduated from high school can find employment in positions which pay well and are greatly preferred to the three years of work and study, without remuneration, offered by schools of nursing.

It is generally known, too, that students of nursing have little opportunity for a desirable social life inasmuch as practically all schools have regulations governing their hours off duty, as well as those spent in the classroom or in practice of nursing procedures.

The public has never been reeducated in regard to nursing and in the minds of numerous people nursing is degenerate and degrading. Many parents object vociferously when their daughters express the wish to enter nursing. Their objection is usually based on the assumption that nursing is a form of menial labor and that nurses are forced to perform undesirable tasks from early morning till late at night.

Many graduate nurses will discourage the young girl who expresses a desire to enter a school of nursing. It

is not uncommon to find a graduate registered nurse who will take every opportunity to point out the *disadvantages* of nursing to girls who might be interested in the profession without bothering to call their attention to the *advantages* which nursing might offer them.

Other problems that affect the present shortage of nurses and which are not generally known by lay people have to do with faults arising from within the nursing profession itself. At the present time no provision is made to recognize the nurse who shows marked ability and special fitness for her profession. For example, general duty nurses are paid and receive privileges in accordance with their status as general duty nurses and with no consideration as to their ability and fitness for the job they are doing.

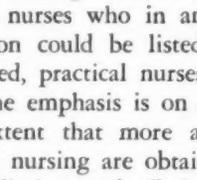
One general duty nurse may be far superior to a second one working in the same department, yet their salaries will be exactly the same, with vacation time, sick leave and holidays accorded the same to each. And the general duty nurse with from ten to twenty years of experience in nursing may receive the same salary as that being given the general duty nurse who has just completed her course of study.

OVEREMPHASIS ON EDUCATION

Then there is the indisputable fact that graduate nurses who do bedside or general duty nursing are looked upon as being in much the same category as a buck private in the army. For too long, leaders in the nursing profession have emphasized the importance of education and of so-called advancement in nursing to the extent that all nurses, even though they may prefer to do general bedside nursing and are greatly needed for that particular service, are made to feel that they have somehow failed in attaining success in the nursing profession if they have not progressed to head nurse or supervisory positions or have not made arrangements to obtain further education which would fit them for a position other than that of a general bedside nurse.

The emphasis on education in nursing seems to have gone from one extreme to another. In former years it was felt that all nurses were properly prepared for the nursing profession if they received a minimum amount of formal schooling with a maximum amount of actual nursing practice. Because of lack of interest or lack of emphasis on nursing education, many schools of nursing turned out graduate registered nurses who in any proper classification could be listed only as well trained, practical nurses.

Now the emphasis is on education to the extent that more and more schools of nursing are obtaining university affiliations and offering courses of study comparable to those given university students. As a result, prac-



tically all graduate registered nurses are trained to believe that nursing is largely a matter of being familiar with theory in complicated professional subjects with little attention or interest given to actual nursing procedures.

Too many young graduates from schools in which education has been emphasized to such an extreme, although theoretically familiar with the routine in regard to reports and records, are not able to combine their theoretical knowledge with good practical experience and often show definite lack of consideration for the actual care being given to the patient.

Another factor, which no doubt should be considered in the examination of this problem of shortage of nurses, is that of the reluctance with which nursing organizations attack problems directly concerned with their profession. At the recent biennial convention held in Chicago much time and energy were expended by nursing leaders in informing their audience that there are far too many schools of nursing in the country today and that research had shown that a large percentage of these schools were inferior to the point where they failed to meet minimum requirements.

INSPECTIONS OFTEN A FARCE

This condition has existed in smaller schools of nursing for a long time and leaders in the nursing profession have been aware of the discrepancies in such schools, but no definite action has been taken to close inferior schools or to see that improvements are made. This would seem to indicate a lack of authority and a failure to act on the part of the nursing organizations.

State board examiners for practically all states in the country have for many years made a farce of examining schools of nursing. Supervisors and instructors and directors of nurses, if questioned, will invariably report that state examiners make little or no effort to become acquainted with the methods of keeping records, with regulations governing students on and off duty, with working facilities in the hospital, and with the type of service to which students are assigned during their three-year course of study.

The many so-called inspections of schools have been conducted with the state examiner and the superintendent of the hospital, or the director of nurses, spending a pleasant half day renewing their social acquaintance, making a perfunctory examination of one or two departments which have been carefully prepared in advance for the inspection, and retiring to a private dining room where they partake of a splendid luncheon which has been especially prepared and is in no way similar to that being served at the same time to students and members of the graduate nurse staff.

DOCTORS UNDEMOCRATIC

Another contributing cause of the nursing shortage which is not generally known to lay people but is well up on the list of disadvantages of nursing as a profession is the practice, which has been in effect for years and which is found in practically all hospitals, of delegating non-nursing duties to members of the nursing staff when other departments in the institution are shorthanded. It is not at all unusual to find the nursing department pressed into service to relieve in business offices, at the switchboard, and in x-ray, pharmacy and other departments.

The attitude of the medical profession has played an important part in producing a shortage of nurses. In far too many institutions doctors give little or no consideration to the nurse who, all too often, has to assume the position of a personal servant instead of that of a recognized and capable helper. At the present time a large number of doctors who are just beginning to be aware of the fact that the shortage of nurses may eventually interfere with management of their

medical practice have consented to appear before groups of prospective student nurses and talk to them on the advantages of nursing.

Those same doctors, after assuring the prospective students that the work of nursing consists chiefly of assisting the doctor in his important work of caring for patients, may go directly to a hospital and treat their so-called assistant as though she were a paid hireling, a necessary evil, and a not-too-bright servant. Through speech or action, doctors often cause a much needed institutional nurse to decide to seek employment elsewhere.

In one instance, a member of the medical profession asked a nurse to write his orders for him and when she reminded him that written orders are the doctor's legal responsibility and the means of ensuring proper treatment for his patient, he informed her with some well chosen, profane language that he was ordering her to write the orders and that it was up to her to do as she was told.

PATIENT NOT CONSIDERED

Too often, nurses in charge of the hospital are forced to conform to the wishes of the doctor even though they know without doubt that the doctor is not considering the welfare of the patient. In one instance a doctor refused to take time to observe aseptic technic in changing a surgical dressing even though the nurse had the necessary supplies at hand. The patient developed an infection and was forced to remain in the hospital for a much longer time than would otherwise have been required.

Many doctors refuse to accord members of the nursing staff the respect and consideration they should have as helpers and assistants. It is not uncommon to have a member of the medical staff refer a patient with a communicable disease to a hospital that does not admit such cases. The doctor may be aware that the patient has active tuberculosis or some other equally communicable disease and yet he will send the patient to the hospital for "observation" or with a diagnosis which he knows to be incorrect, but which will be acceptable at the hospital. When this happens, graduate and student nurses who care for the patient are exposed to the disease and are not given an opportunity to observe ordinary precautions which might prevent them from contracting it.

In one school of nursing, forty students were given pins and diplomas, forty girls who had worked three years with members of the medical staff at their hospital, girls who were proud of their accomplishment and anxious to have it recognized by others. An invitation to commencement exercises was sent to each doctor and from a group of approximately sixty, the only one present at the exercises was the president of the medical staff who appeared on the program. He stated later that "if I hadn't been obligated to speak, I would not have been able to attend."

These young graduate nurses could not be easily convinced that nursing brings to them an opportunity to be a respected co-worker or assistant to the medical man. By staying away from the commencement program, the doctors had made all too clear their lack of interest in the student nurses and the small regard they had for them as associates.

Responsibility for the nursing shortage rests also on the boards of directors, or trustees, of the hospitals.

Nurses are constantly hearing that their needs in the way of supplies and equipment cannot be met because of "the Board." Salaries can not be increased without sanction of "the Board." If desirable personnel policies can not be obtained, it is because of "the Board." If administrative policies are disregarded in some instances, it is usually for a patient who is a member of, or related to, "the Board."

THERE ARE SACRED COWS

A good supervisor may serve for years in a hospital rendering excellent care to numerous patients and no recognition will be given her for her efforts in the patients' behalf—but if she fails to please someone on the board, or a friend of someone on the board, she is likely to be severely criticized.

In a small Midwestern hospital, a capable assistant head nurse was dismissed from the staff because she attempted to move a patient from a private room to a semiprivate room in order to make the private room available to an emergency case. This practice was common in the hospital in which she was employed, but she made the mistake of asking the brother-in-law of a board member to move from the private room. In spite of the fact that the director of nurses explained the situation to the irate member of "the Board," the assistant was dismissed.

In another institution a director of nurses was notified to dismiss an orderly from duty. The orderly had worked at the institution for three years. The nurse objected, saying that the orderly's work was satisfactory and that he was needed. She pointed out to the superintendent of the hospital that the orderly was the father of two children, had recently bought a small home, and that his wife had been seriously ill a few months before. The superintendent himself dismissed the orderly, giving him as a reason the fact that it was necessary to reduce the hospital pay roll. Three days after dismissal of the qualified orderly, the director of nurses was instructed to hire a young man seeking work as an orderly. The young man was inexperienced and lacking in required personal attributes, but he had been told he could have the position by the president of "the Board."

WHEN, AS AND IF

When "boards" understand the importance of placing well trained administrators in charge of hospitals and then giving them the needed authority to perform the job successfully; when boards and administrators stop hiring relatives and friends of boards and administrators unless they can qualify for their positions; when administrators begin to establish and enforce desirable policies in regard to hospital personnel; when members of the medical staff place the hospital and the patients' welfare ahead of their own personal and selfish interests; when capable directors of nurses are allowed to direct the schools and nursing service as they wish without being restricted by boards, administrators and medical staffs; when nurses are given the recognition and consideration merited by their training, experience and ability, then we may expect to find a marked decrease in the existing shortage of nurses.

SMALL HOSPITAL FORUM

COSTS ARE UP 114 PER CENT IN THESE HOSPITALS

Survey shows many are using A.H.A. manual of accounts and federal reimbursable cost formula

IN A GROUP of small hospitals whose cost figures and methods were studied for the Small Hospital Forum, the average cost per patient per day had increased from $5.92 in 1940 to $12.69 in 1948—or a little more than 114 per cent.

Eighteen hospitals, ranging in size from forty-four to 160 beds, were included in the survey. The hospitals were located in various sections of the country and types of community, and the group was too small for variations in cost from section to section or city to city to have any significance.

The highest cost reported was $20.98 per patient day. This was reported by a ninety-five-bed hospital in one of the western states. In this instance, the cost had increased 124 per cent, or slightly more than the average over the period covered in the survey.

Lowest per diem cost reported in this group of hospitals was $7.66, the figure furnished by the one Canadian hospital in this group. This cost, it was stated, reflected an increase of exactly 100 per cent since 1940.

Most of the reporting hospitals stated that the cost figure given included a charge for depreciation on buildings and equipment, although several reported that no depreciation charge was included. The stated depreciation charge in the only case in which this figure was given was 60 cents per patient per day.

Hospitals participating in the survey were also asked to state the percentage increase in pay roll cost since 1940. These increases ranged from 22 per cent in one case to an astonishing 528 per cent in another. The average percentage increase in pay roll costs for the entire group of hospitals was 237. Accounting for several of the large pay roll cost increases was the fact that in 1940 several of these hospitals were reimbursing many, if not all, employes in maintenance as well as cash but had shifted to an all cash basis by the time the later pay roll figure was reported. This factor cannot be definitely identified from the figures furnished but was mentioned by several administrators reporting excessive pay roll cost increases.

In this group of hospitals, eleven, or slightly more than half, use the standard chart of accounts as set forth in the American Hospital Association's manual on accounting. In reply to another query, it developed that several of the hospitals not now using the A.H.A. chart of accounts had copies of the manual on hand and were considering its adoption in accounting procedures. Among those not

COST ACCOUNTING PRACTICES IN SMALL HOSPITALS

REGION	BEDS	DAILY COST TODAY	COST 1940	PER CENT INCREASE	PCT. PAY ROLL INCR. 1940-48	USE A.H.A. MANUAL?	CASH OR ACCRUAL	USE GOVT. REIMB. COST FORM?	OUTSIDE AUDIT
East	147	$12.03	$5.61	114	171	—	A	no	annually
East	105	11.01	4.61	138	334	no	A	no	monthly
East	100	15.79	7.96	98	83	no	C	yes	annually
Midwest	160	12.80	6.57	95	338	no	A	no	annually
Midwest	75	9.02	4.02	124	458	yes	A	no	annually
Midwest	44	13.18	5.49	140	528	yes	A	no	annually
South	118	10.95	6.21	76	258	yes	A	no	quarterly
Southwest	125	12.28	5.84	110	244	no	—	no	monthly
Southwest	100	10.00	—	—	40	yes	A	yes*	annually
Southwest	160	9.89	5.42	82	175	yes	A	yes	annually
Southwest	135	16.82	7.29	131	22	yes	A	yes	monthly
Mountain	111	12.58	—	—	—	—	A	yes	monthly
Mountain	125	10.50	6.50	62	60	yes	A	yes	annually
West	95	20.98	9.37	124	500	yes	A	yes	annually
West	135	14.81	4.73	213	451	yes	A	yes	annually
West	100	12.53	5.38	133	138	yes	C	no	annually
West	125	15.73	—	—	50	yes*	A	no	annually
Canada	85	7.66	3.83	100	175	no	A	no	quarterly
Average		$12.69	$5.92	114	237				

*With modifications.

using the chart of accounts, two hospitals were using standard forms recommended by the local hospital council. One was a government hospital using standard state accounting forms and another said that its book of accounts was "generally comparable" to the recommended breakdown in the A.H.A. manual.

Only two of the hospitals in this group keep books on a cash basis; in all the remaining hospitals, the accrual method is in use. All but two of the hospitals regularly determine direct major departmental costs (such as administration, dietary, professional). One of the accompanying tables presents the average departmental cost breakdown for hospitals in one state on the basis of a cost formula worked out with the state Blue Cross plan. The hospital furnishing these figures noted that its own cost breakdown corresponded closely to the weighted average for the state as furnished in the Blue Cross study.

Departmental Costs per Patient Day

(Average figures for hospitals in one state as reported on uniform cost formula for Blue Cross)

DEPARTMENT	COSTS
Administration	$ 0.70
Dietary	2.24
Laundry	0.51
Housekeeping	0.68
Heat, light, power and water	0.48
Maintenance and repairs	0.26
Motor services	0.01
Medical and surgical services	0.99
Nursing service and education	2.89
Medical records and library	0.14
X-ray—diagnostic	0.34
X-ray treatment	0.06
Laboratories	0.39
Pharmacy	0.32
Other special services	0.19
Total per diem charge	$10.20

Eight of the respondent hospitals stated that they are using the federal reimbursable cost formula developed by the American Hospital Association as the basis for negotiating rates for welfare cases with city, township, county or state agencies. In one or two cases, it was stated that the formula was used with some modification. On this point one administrator commented that the formula was not being used "because we cannot obtain more than $10 a day anyway." Another administrator said the formula was not used "because we charge full rates to all governmental agencies."

Rather surprisingly, many of these hospitals are having their books examined by outside auditors oftener that the customary once a year. Two of the hospitals have a quarterly audit and four hospitals are audited by an outside firm once every month. The remainder have an annual audit. "This is probably unusual" one administrator acknowledged in reporting the monthly audit, "but we have the services of an auditing firm which makes up our complete financial report each month at a very reasonable cost."

The Only Hospital of Its Kind

CARVER Memorial Hospital of Chattanooga, Tenn., was opened to the public July 1, 1947. Its purpose is to provide a modern hospital for the private, colored patients of the eighteen colored doctors who are practicing medicine in Chattanooga.

Control of Carver Memorial Hospital is under the board of trustees of Baroness Erlanger Hospital, which purchased the site and building. It is, therefore, owned by the city of Chattanooga and the county of Hamilton. It is thought that this is the only municipally operated hospital, operated for the exclusive use of Negro doctors for their private patients.

The building was purchased and modernized at a cost of approximately $150,000, all of this money being raised through private donations from the citizens of Chattanooga. The equipment is the most modern possible. There are modern delivery rooms; it has a complete laboratory and x-ray department. The fifty beds are mostly in private rooms.

The staff is completely organized and functions under the latest constitution and by-laws of staff organization. The doctors have furnished and equipped a fine meeting room and library in the hospital. The hospital has the advantage of full consulting service from the departments of Baroness Erlanger Hospital, such as pathology and x-ray. Purchasing for the hospital is also done through the Baroness Erlanger Hospital.

A full staff of Negro registered nurses constitutes the nursing service. There is an active auxiliary which has rendered fine service and several other local organizations have made gifts for the hospital.—A. F. BRANTON, M.D., *administrator, Baroness Erlanger Hospital, Chattanooga, Tenn.*

Doctors and nurses gather on the steps of Carver Memorial Hospital.

ABOUT PEOPLE

Administrators


Dr. R. H. Lowe

Dr. Robert H. Lowe has been appointed medical director of Rochester General Hospital, Rochester, N.Y., succeeding **Dr. Frank C. Sutton,** whose resignation was reported recently. Dr. Lowe received his master of science degree in June 1947 from Columbia University, where he did postgraduate work in hospital administration.

Dr. Roger W. DeBusk, executive director of the Evanston Hospital, Evanston, Ill., since 1941, resigned last month. Dr. DeBusk said the move was made for personal reasons and that he was not ready to announce his future plans. Dr. DeBusk is a past president of the Chicago Hospital Council and district chairman of the Illinois Hospital Association. Before going to the Evanston Hospital he was assistant director of St. Luke's Hospital in New York City.

Dr. Eugene B. Elder, superintendent and business manager of Flagler Hospital, St. Augustine, Fla., retired from the hospital field November 1, completing nearly forty-five years as a hospital administrator. Dr. Elder has been superintendent and business manager of Flagler Hospital for the past four years. He was one of the eighty-three members present at Buffalo, N.Y., in September 1906 at the meeting of the Association of Hospital Superintendents, where the American Hospital Association was organized.

Dr. Elder will be succeeded by **John R. Purcell** of St. Augustine, Fla. Mr. Purcell has been associated with Dr. Elder since July 1 of this year.

William Turner, assistant administrator at Truesdale Hospital, Fall River, Mass., has resigned to become administrator of the Newport Hospital, Newport, R.I.

Dr. L. C. French resigned recently as administrator of the Knickerbocker Hospital, New York City, it was announced by the hospital board.

V. R. Hylton has been appointed administrator of the King's Daughters' Hospital, Martinsburg, W.Va. For the last two years Mr. Hylton has served as administrator of Pulaski Hospital, Pulaski, Va. Prior to his service in the medical administrative corps during the war he was associated with the Convalescent Hospital of Philadelphia.

Walter W. N. Righter has retired as managing director of the Presbyterian Hospital in Philadelphia, it was announced in the bulletin of the Hospital Council of Philadelphia. Mr. Righter was succeeded by **John C. Atwood Jr.,** formerly assistant director, the announcement said.

M. E. Heitmeier is superintendent of of Tilden Hospital, which opened last month in the former Barr Memorial Hospital property at Tilden, Neb., under the auspices of the Tilden Hospital Association, a nonprofit community group.

Harry Payne became administrator of the McKinney City Hospital, McKinney, Tex., September 1. Mr. Payne was purchasing agent for Jefferson Davis Hospital, Houston, for two years and, prior to that, served in the same capacity at Memorial Hospital in Houston.

Richard J. Stull has been named general superintendent of hospitals and infirmaries for the University of California. In his new position he becomes an associate clinical professor of hospital administration at the university. His administrative jurisdiction embraces university hospitals in San Francisco and Los Angeles, and infirmaries at Berkeley, Davis, Los Angeles and Santa Barbara.

Sister M. Maxentia has been appointed Superior of St. Mary's Hospital, North Platte, Neb., succeeding **Sister Mary Judith.**

Charles T. Davis, former business manager of Memorial Hospital, Corpus Christi, Tex., is now administrator of the Ghormley Clinic Hospital in Corpus Christi.

Paul Meyer Jr., director of the Citizens General Hospital, New Kensington, Pa., will join the administrative staff of the Jewish Hospital of Brooklyn, N.Y., on December 1 as associate director in charge of business management.

Stephen Taras has been appointed superintendent of Chadron Municipal Hospital, Chadron, Neb., succeeding **Corrine Voight.** Mr. Taras, a World War II veteran, served as assistant chief nurse in a 200-bed base hospital in the South Pacific area. He holds his R.N. degree from Mills School of Nursing, Bellevue Hospital, and his B.S. from Columbia University.

C. F. Fielden Jr. has been named superintendent of the Southeast Texas Baptist Hospital, Beaumont, Tex.

Garret P. Snyder has been appointed assistant manager of York Hospital, York, Pa.

Otto F. Keller has been named acting administrator of the Denver and Rio Grande Western Hospital, Salida, Colo. For many years Mr. Keller was associated with the Lutheran Hospital and Homes Society of America. While in Nebraska he was administrator of the Dodge County Hospital in Fremont and was president of the Nebraska Hospital Association for one year.

William Hudgins has been named acting administrator and business manager of Harris Hospital, Fort Worth, Tex., until a successor is named to replace **Tol Terrell.**

Charles R. Wylie, who returned to this country recently after thirty-four years in the Near East as an oil company representative, has been appointed administrator of Pottstown Memorial Hospital, Pottstown, Pa. During the last ten years Mr. Wylie was a member of the Istanbul board of managers of the Admiral Bristol Hospital in Istanbul, Turkey. He was president of the board for seven years.

William K. Turner, former assistant superintendent and assistant treasurer of Truesdale Hospital, Fall River, Mass., has resigned that post to become director of Newport Hospital, Newport, R.I.

Eloise Furnival, graduate of the Northwestern University course in hospital administration, has been named administrative assistant at Muhlenberg Hos-

(*Continued on Page* 182.)

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No involved procedures with Cutter Solutions in Saftiflasks! From meticulously tested solutions—to ready-to-use, disposable injection equipment—the Saftiflask set-up is designed for simple, trouble-free administration in your hospital.

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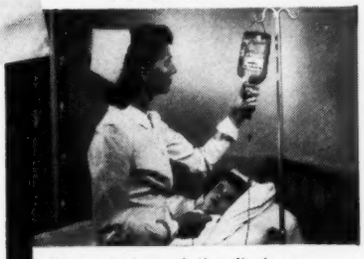
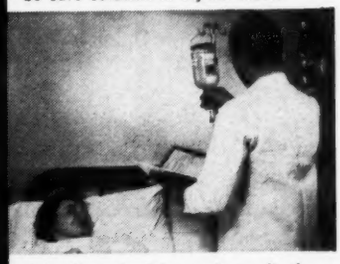


When placing solution flask on stand, nurse makes final check to be sure solution is crystal clear.



Attending physician makes a final examination, to be certain solution checks with his written orders.

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LET'S NOT CUT OFF OUR SERVICE ARM

JAMES E. STUART

Executive Director, Hospital Care Corporation
Cincinnati

THE relationship between hospitals and their depression-born child—Blue Cross—appears at times to be threatened both locally and nationally. In some areas hospitals have withdrawn from participation in Blue Cross and in others have threatened such action. Nationally, the necessity of Blue Cross's being an integral part of the American Hospital Association has lately been questioned.

The reasons for such feelings between parent and child are partly inherent in the relationship, and partly due to the rapid growth and development of the offspring; however, they are largely due to outside economic problems created by postwar inflation.

So long as wages and prices remained under governmental restrictions, fairly good relationships between Blue Cross and participating hospitals were not too difficult to maintain. Serious obstacles to cooperative relationships appeared late in 1945 in some areas, or the early part of 1946 in others, when hospital costs began to shoot upward after the elimination of price controls.

HAD TO RAISE CHARGES

To meet these conditions most hospitals had only one resource—to increase the income from patients by raising charges for all services. Blue Cross generally was not prepared to meet these increased charges and in many areas fought long delaying battles to prevent the increases from becoming effective for their members. The failure of Blue Cross management to understand the urgency of the hospitals' plight, the struggle to postpone the inevitable upward adjustment as long as possible, in some areas led to an almost complete breakdown of the family relationship between the hospitals and Blue Cross.

On the other hand, the hospitals were slow to understand the Blue Cross problem. To make any change in subscribers' contracts involving a decrease in benefits or an increase in subscription fees, or both, is an extremely difficult undertaking. From the standpoint of public relations and the great amount of internal clerical details involved, such changes are almost catastrophic. To be forced to make rate and benefit adjustments more than once appeared almost fatal in any movement involving a large number of individuals accustomed to absolute stability of premium charges for other insurance protection.

The basic problem of relationship between hospitals and plans must be worked out in the local plan areas. It cannot be solved on the American Hospital Association-Blue Cross Commission level. This problem of relationship represents today the largest single public relations problem of Blue Cross and the hospitals. Regardless of all its fumbling, Blue Cross has now become so well accepted by the public generally that the community would not consider giving it up. Yet, unless Blue Cross and the hospitals in each plan area can work out what, in reality, is a simple problem, Blue Cross may have to be replaced by a compulsory governmental program.

The people have now been educated to the point where they will demand a satisfactory method of prepaying their hospital bills. Blue Cross may well fail to be a satisfactory method when it cannot provide some stability of benefits and rates on a service rather than a cash indemnity basis; or when participating hospitals no longer guarantee the benefits of its subscribers' contract.

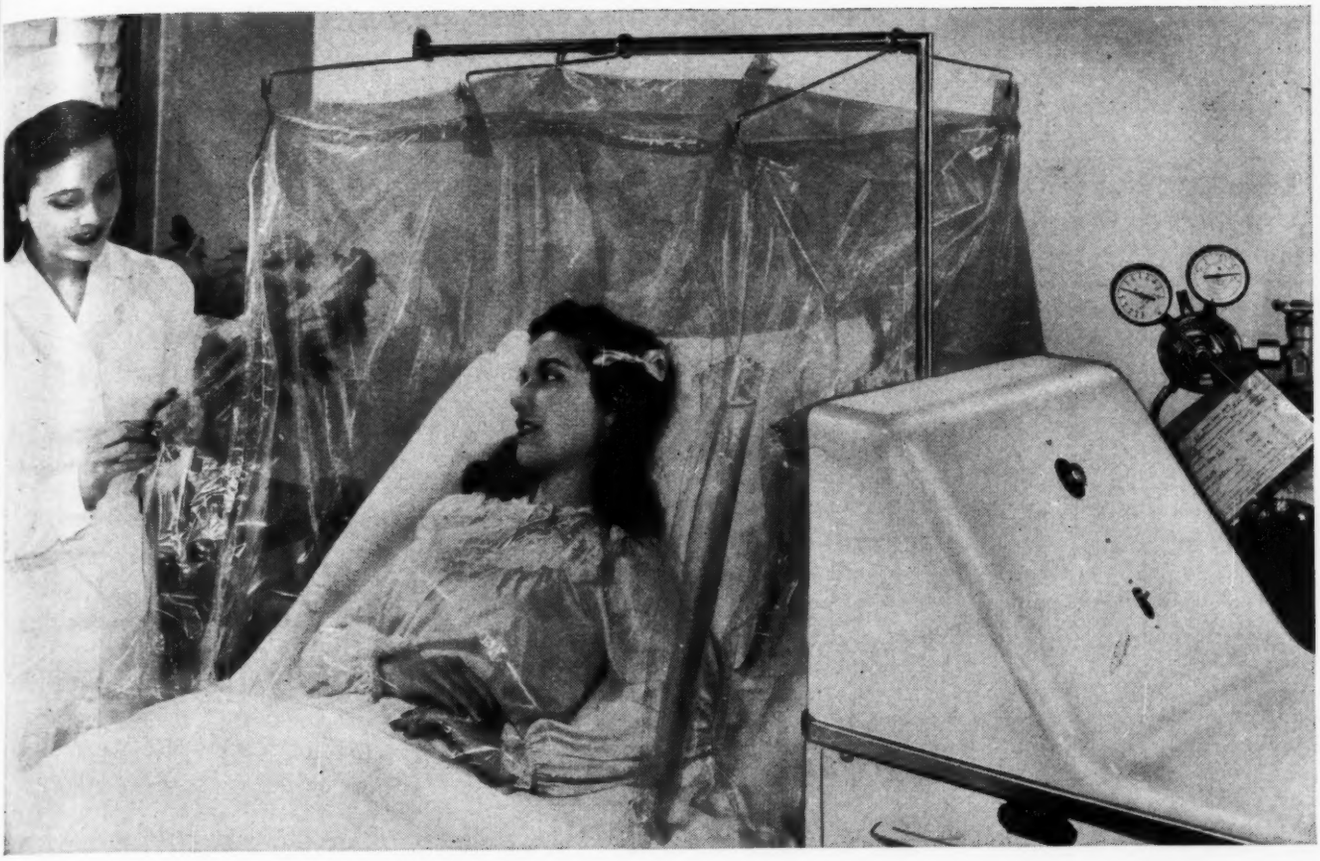
The experience in Cincinnati might be of interest and helpful in pointing the way to one method of successful cooperation between plan and hospitals. Hospital Care Corporation is a Blue Cross plan established little more than eight years ago, covering fourteen counties in southwestern Ohio and having a membership of 740,000, or almost exactly half of the total population of the area served. Outside of the initial problems, which were solved by trial and error methods during the first two years of the plan's existence, there have been no serious misunderstandings between participating hospitals and the plan. On the contrary, there has been an attitude on the part of the hospitals that it is their responsibility to protect the plan from abuses and to deal with Blue Cross as they would deal with a member of the family—to consider the plan as the service arm of the hospitals.

WORKABLE AGREEMENT REACHED

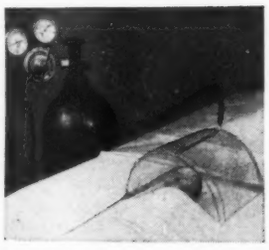
This relationship did not come by accident but through many conferences between plan and hospital management in which problems were placed on the table, discussed and even fought over until some workable agreement was reached.

Each hospital is represented on the Blue Cross board of trustees by a member of its board of trustees, and the administrators and business managers of all participating hospitals constitute an advisory council which meets whenever there are matters which either plan or hospital administrators wish to discuss. This provides a method whereby plan and hospitals meet on the management rather than trustee level.

No matter affecting subscribers' benefits or hospital relations is presented to the board of trustees until after it has been presented to the advisory council, and no action is taken



OXYGEN THERAPY + VISIONAIRE CANOPIES = PATIENT SATISFACTION



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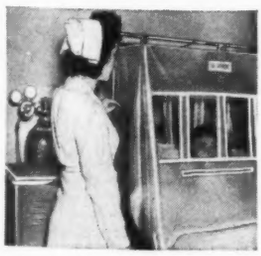

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Use of Visionaire Canopies permits the patient to become a part of the room, with full vision and ready observation by attendants.

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CONTINENTAL HOSPITAL SERVICE, INC.

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by the board of trustees concerning such matters until after it has been referred to the advisory council for consideration and report. In this way, every hospital administrator has a chance to present and discuss his position on any problem relating to Blue Cross. (The subscribers' council, composed of elected representatives of the subscribers, functions in the same way in regard to subscribers' benefits and rates.)

BENEFITS WERE INCREASED

In the early part of 1943 Blue Cross management decided it would be well greatly to increase the benefits under the subscribers' contract by providing all the services ordinarily appearing on the hospital bill without limitation as to amount, cost or usage, except as to room accommodations. This meant that x-ray, drugs and laboratory service would be provided as ordered by the physician and paid for by Blue Cross. Diseases formerly excluded were covered so that when Blue Cross members entered a member hospital for treatment there would be no question as to coverage because of diagnosis, type of service, or amount of medications used.

This new subscribers' contract was approved by the board of trustees to be effective Oct. 1, 1943, after full consideration and approval by the hospital administrators and the subscribers' council. At the same time, it was determined that the hospitals should be reimbursed on the basis of their regular billing charges not to exceed their published charges as of July 1, 1943, with the provision that further increases in charges would be effective for Blue Cross patients only after ninety days' notice and after approval by the plan's board of trustees.

In effect Blue Cross became responsible for unlimited service for all types of hospital admissions of its members, except for purely diagnostic check-ups and admissions covered by state or federal laws. It was understood that the plan would be protected by the advisory council against abuses of all kinds. As had been anticipated, within four months the per patient per diem charge for x-ray examinations had almost doubled, the use of costly drugs had increased, and the doctors were ordering expensive laboratory work-ups oftener than formerly.

In a series of monthly meetings with the advisory council, Blue Cross presented the problem, the facts and the need for control. The hospital administrators assumed their responsibility for instituting the necessary procedures and educating their medical staff; the problem of controlling usage and cost with an unlimited contract, for the time being at least, was satisfactorily solved.

Because of the rapidly increasing hospital costs, Blue Cross raised its subscription rates in August 1946 but, like other plans, did not raise them sufficiently to take care of unforeseen continued price increases.

Since the subscribers' contract provided for payment for all drugs without limitation, the great use of penicillin after the war seemed at times to threaten the very financial stability of the plan. The advisory council agreed to a uniform reduced sliding scale of charges to Blue Cross so that the charge decreased as penicillin came down in price.

Streptomycin came along in the fall of 1946 at an almost prohibitive cost. Here, again, the hospital administrators agreed to charge Blue Cross the bare actual cost of the drug with no mark-up for a period of three months while usage and price were being stabilized. At the end of that time the cost of the drug to the hospitals plus 40 per cent mark-up was agreed upon as a uniform price.

It became obvious in early 1947 that the continued upward spiral of inflation would make necessary another adjustment in subscription rates or benefits. Our subscribers' committees, group leaders and selected groups of members were asked by questionnaire to give their preference as to decrease in benefits or increase in subscription rates.

PEOPLE DID NOT UNDERSTAND

The response to this questionnaire indicated that the community at large did not understand why the hospital costs were so high. Many felt that all hospitals were getting rich; inasmuch as they were all crowded they must be making money. Some expressed dissatisfaction with the service they had received in hospitals; others gave vent to complaints about hospital management generally. Most business men felt that a large volume and rapid turnover of patients indicated that unit costs should be lower rather than higher.

A public relations program on behalf of the hospitals seemed urgently necessary. The replies from these employed groups were analyzed and discussed with the advisory council and unanimous agreement was reached with the Blue Cross recommendations that before any changes in rates or benefits were made the public should know why hospital costs were so high, and why they probably would go higher.

In the meantime, per diem ceilings on Blue Cross payments had been imposed and Blue Cross undertook to produce and finance on behalf of the hospitals a series of newspaper advertisements detailing the amount of increase in costs by item and comparing the costs of 1947 with the costs of 1942. This comparison showed almost a 100 per cent increase.

COMMUNITY WAS INFORMED

A public meeting was staged at which a national authority in the hospital field presented the hospitals' financial predicament; editorial comment was obtained; radio time was donated as a public service, and altogether a period of three months was devoted to informing the community why the hospitals had to charge more for their services in 1947 than before the war.

The last advertisement of the series was an endorsement by the hospitals of Blue Cross as the best way to pay higher hospital bills. A month later the subscribers' contract changes and rate adjustments were announced to be effective Feb. 1, 1948. The adjustments were then made without difficulty and almost without complaint.

During February and March each participating hospital arranged for a special meeting of its medical staff at which Blue Cross was presented and discussed fully. These luncheon and dinner meetings arranged by the hospital administrators were well attended. The meal was provided by the hospital. The formal presentation lasted about fifteen minutes but the discussion often lasted an hour or more.

For the first time, Blue Cross management had the opportunity to talk directly to a large percentage of all practicing physicians in its area, at a hospital staff meeting, at which Blue Cross was the chief topic. This was arranged by the hospital administrator so that the medical staff could discuss a vital part of the hospitals' own program—their nonprofit prepayment plan.

Recently, at the hospitals' request,

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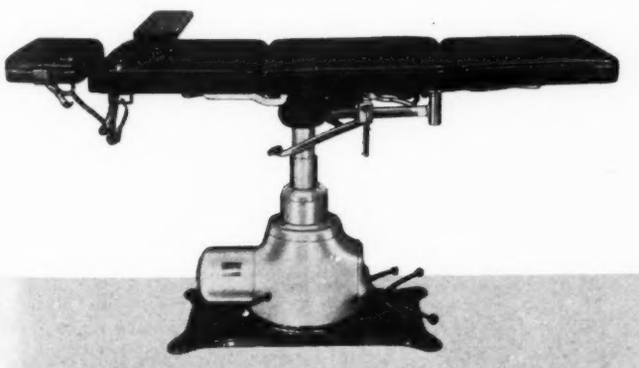

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a successful student nurse recruiting campaign was handled in their name and at their expense by the Blue Cross plan. For this purpose the full-time service of the public relations department of the plan was lent to the "Careers in Nursing Campaign" for a period of almost three months.

In March and April of 1948 current studies again revealed an excessive usage of expensive medications and the advisory council was asked to study the matter and see what could be done. As a result of these studies and meetings of the hospital administrators with Blue Cross management, controls were instituted by the hospitals on usage of drugs, laboratory procedures and x-ray examinations.

THREE-DAY RULE INSTITUTED

A standard mark-up on certain drug prices was agreed upon, resulting in savings to Blue Cross; a three-day rule was instituted which provides that a series of daily procedures ordered by the doctor automatically stops at the end of three days unless it is specifically continued at his direction. (It was discovered that in many cases the doctor ordered a continuing series of tests or medications, and when he forgot to discontinue them when the need no longer existed, the hospital continued to pile up patient costs unnecessarily.) The length of stay was checked and measures were taken to shorten it where possible. All these actions were taken by the hospitals of their own volition after a presentation and study of the facts around the table with the Blue Cross management.

The net result of this type of cooperation is that Blue Cross can still provide service without limitations as to cost, amount or degree of services without exclusions from coverage, and at reasonable subscription rates. All this is certainly to the benefit of the subscriber, the community and the hospitals. Hospitals are still paid their billing charges and the Blue Cross plan has not yet completed a year of operation without some addition to its reserves.

This achievement in relationship between hospitals and plan came through a willingness on the part of both to discuss mutual problems openly and frankly and through the desire on the part of all to arrive at a fair conclusion. Difficulties, which appeared at times almost insurmountable, were overcome when all the facts and possibilities were freely discussed and frankly explored. It is truly remarkable how many apparently serious problems evaporate when all parties sit around the table with a willingness to reach a mutually desirable solution.

Many leaders in Blue Cross indicated as recently as the March meeting in Los Angeles that their biggest problem was relations with participating hospitals. If that is true, it would seem logical to use the best personnel on the staff in an effort to achieve a good working relationship between the plan and the hospitals that guarantee its benefits.

It is true that in the fourteen-county area of the Cincinnati Blue Cross plan it is possible for all the administrators and business managers of the hospitals to get together in monthly meetings with plan management and thresh out problems. But statewide plans present a problem different only in area and not in detail. Regardless of the area covered by the plan, it would seem that district organizations could be effected and district meetings could be held as often as necessary.

For larger plans it might be well to have two or three trained and experienced Blue Cross staff members in the field spending their full time in working out problems with member hospitals, individually and in groups. These problems cannot be solved through the use of a typewriter, duplicating machine or telephone at the Blue Cross headquarters. The time is here when a Blue Cross plan should consider the importance of its hospital relations as they affect membership and the community at large.

If hospitals are to continue as voluntary community agencies and if Blue Cross is to continue to grow and develop as the service arm of the hospitals, misunderstandings between plan and hospital management must be eliminated. If the hospitals are to avoid having the government as their chief customer, with eventual governmental control and direction, they cannot afford to let Blue Cross be anything else but an essential integral part of their program of health service to their community.

For the benefit of all the people of the community, the relationship which started as that of parent and child must be continued as a joint cooperative partnership of the hospitals and Blue Cross. Blue Cross has achieved its majority and, although the relationship has changed somewhat, the interdependence of Blue Cross and the hospitals and the necessity for united action remain unchanged.

In every Blue Cross plan area unity of purpose and action can be accomplished if there is a willingness on the part of hospitals and plan management to look at their mutual problems from the point of view of the community. This will require frank and full discussion with all the cards on the table, the creation and use of some simple machinery, such as our advisory council, for getting together on the management level, the exercise of a modest amount of imagination in recognition of common goals, and the assumption of leadership in achieving common objectives.

The voluntary hospitals of America have created and the plans have developed the most significant movement in the history of the country—we call it Blue Cross. But it is simply a method whereby the benefits of hospital care can be made available when needed on a voluntary nonprofit prepayment basis. For the benefit of the hospitals? Yes, but only incidentally! The much larger benefits to the community as a whole are much more important.

VOLUNTEER ACTIVITIES

"Under Any Name"

It has been a good year for Memorial Hospital, Philadelphia, as far as women's activities are concerned. On October 1 the Ladies' Aid officially became the Women's Board, a name calculated to provoke greater community interest and support.

Community support, however, has not been lacking under the old name. Last summer's lawn fete netted $7000 despite a downpour just as the lawn supper was over. The women for the first time had provided awnings over the booths, and these protected their wares from a soaking.

Most spectacular of the equipment the women have purchased for the hospital this year is a new ambulance, which cost $4000 and which replaced an ambulance mechanically so crippled that it went out of service in August. The group not only bought the ambulance but paid for the insurance and will provide for its maintenance and operation.

MEDICINE AND PHARMACY

"SOBERING UP" IS A SERIOUS MATTER

Z. MILES NASON, M.D.
Kansas City, Kan.

THE sobering of a drunk-sick alcoholic, frequently regarded as no more than a minor problem, can be accomplished without undue immediate or postperiod suffering on the part of the patient by employing the methods hereinafter described. If he is not so treated effectively, sanely and humanely, the alcoholic may, and frequently does, develop severe mental and physical complications.

The number of alcoholics found dead, often of unknown or ill defined causes, in jails, institutions, hotels and alleys attests to the seriousness of this problem.

The methods described here have been followed in the sobering up of more than 3000 alcoholics, through Alcoholics Anonymous groups in Greater Kansas City, over a period of between five and six years. The system was arrived at following hundreds of experiments using various other methods or combinations thereof.

This detoxicating procedure readily and safely administered by a layman employs alcohol in the tapering off process. This has been found to eliminate the severe shock to the patient that is so often caused by sudden withdrawal of alcohol, which frequently necessitates the administration of other sedatives for varying periods of time to counteract the extremely nervous state of the alcoholic. Temporary use of sedatives may be harmful to the alcoholic in the end by encouraging drug addiction. The use of alcohol, on the contrary, introduces no new dangers.

It should be noted that the use of sedatives or narcotics for nervousness in the alcoholic means but temporary relief inasmuch as greater nervousness results with the wearing off of the drugs. Also, alcoholics as a group experience a far greater narcotizing effect from barbiturates and opiates than do nonalcoholics; consequently, these drugs should not be used in the sobering of the alcoholic.

A further factor which contributed to the evolution of this sobering up procedure is the fact that alcohol is the only sedative which, within limits, can be safely administered by laymen.

Tapering-Off Process of Detoxication

The patient is given 2 ounces of whisky diluted with 6 ounces of water, with treatment started immediately if the patient is nervous. This dosage is repeated at three-hour intervals for a total of five doses. After the fifth dose a six-hour interval is allowed, after which the same amount of whisky in the same amount of water is given and is repeated at six-hour intervals for a total of three doses.

In addition to the dilute whisky doses, the patient is given a teaspoonful of common table salt dissolved in a glass of water, one hour after the second and again one hour after the fourth dose of whisky.

During the intervals between the doses of dilute whisky the patient is urged to drink black coffee containing one or more teaspoonfuls of sugar. (The sugar part of the treatment should be modified in the case of a diabetic patient.) The foregoing procedure allows for a reduction of alcohol consumption over a thirty to thirty-three hour period. If the patient is not mentally clear at its conclusion, hospitalization (usually for from seven to fourteen days) will be required.

In extreme cases the dilute whisky (2 ounces in 6 ounces of water) treatment may be continued for as long as sixty hours with ten doses at three-hour intervals and six doses at six-hour intervals. It is important that the judgment of the person attending the patient be tempered with kindness and sympathetic consideration and if there is a question of extra drinks, they should be given rather than withheld, but not more frequently than at three-hour intervals.

Treatment by Physician

Treatment of the alcoholic by a physician is essential in the case of a patient who manifests one of the following three conditions:

1. Acute alcoholic mania. This condition is characterized by a temporary complete dissociation in regard to time, place or person.
2. Acute convulsions or spasms. These resemble epileptic seizures (grand mal type).
3. Delirium tremens. In this condition the patient is often oriented regarding persons, place and time but has bizarre delusions, with insight, however, into their delusional nature. These conditions may first occur several days after drinking has stopped.

The following course of medical treatment will usually restore the patient who exhibits any of these three conditions to mental clarity.

The patient is given, in a single injection intravenously, 50 cc. of 50 per cent dextrose, to which are added 10 units of regular insulin and 1 cc. of vitamin B complex solution. The same injection is repeated at four-hour intervals for a total of from three to five doses as indicated by severity of the symptoms. After the final injection, the tapering off detoxication process using dilute whisky, as described, is begun.

Experience gained in the course of the hundreds of treatments of this kind indicates that the newly detoxicated alcoholic should be advised and strongly urged to associate himself promptly with the nearest group of Alcoholics Anonymous. For many, this offers the only certain method of obtaining sobriety.

It should be borne in mind that alcoholics are usually in a state of acute distress by the time they apply for help and treatment. In most cases they exhibit the following basic conditions.

1. Mental depression, showing considerable variance from individual to individual.

2. A low chloride level in the blood. This may be due to decreased intake of salt, or to complete failure to ingest salt, especially during the final stage of a drinking bout when little or no food is eaten. Depletion of chlorides may also result from loss of hydrochloric acid from the stomach as a result of excessive vomiting, or as a result of excessive perspiring.

3. A low sugar level in the blood owing to decreased carbohydrate intake as result of failure to eat, and also, in part, to the depletion of sugar reserves consequent on increased metabolism of alcohol.

4. Dehydration resulting from vomiting, reduced intake of water, and excessive perspiration.

The method of treatment, to be successful, must include measures aimed at recovery of these basic conditions.

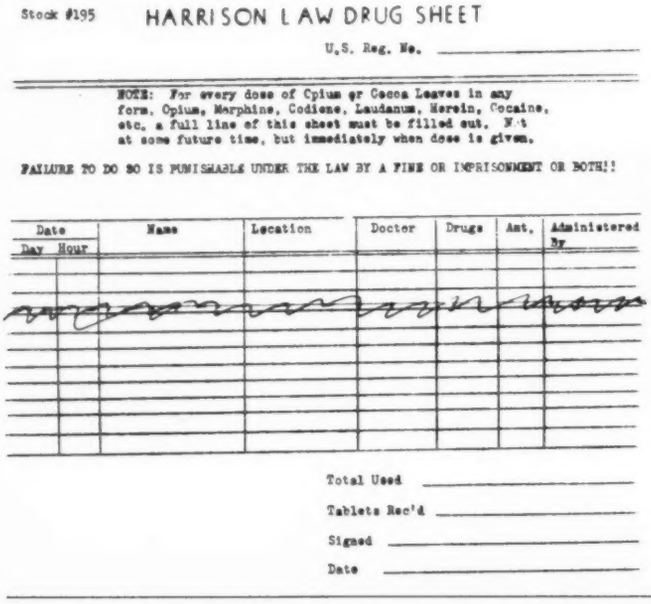
DRUG LAWS NEED GOOD TEETH

L. T. LYON

Senior Pharmacist, Hurley Hospital, Flint, Mich.
President, Michigan Society of Hospital Pharmacists

THE Harrison Act which regulates the sale of narcotics is a federal law. Hospital records for narcotics must be as simple as possible but adequate to keep an accurate check on all narcotics used in the hospital. Orders for all narcotics to be dispensed must be written on the physician's hospital order sheet and signed by a licensed physician. Narcotics classified as floor drugs are issued to the floors in bottles containing twenty-five tablets each on a narcotic requisition marked "floor stock" and may be dispensed on the basis of this order sheet. The signature of the registered nurse is necessary when this stock is delivered.

Each floor keeps a separate "Harrison Law" drug sheet of each narcotic stocked on the individual floor. (See Figure 1.) This sheet is spaced for twenty-five entries specifying date, hour administered, patient's name, room number, physician, drug, amount administered, and by whom administered. When this sheet is completed with twenty-five entries and properly signed by a registered nurse, it is returned to the pharmacy, and twenty-five tablets are given to the nurse to replace the amount used. Narcotics are delivered to a registered nurse only, never to a student nurse, orderly or auxiliary personnel. (See figure 2.) Any narcotic not classified as a floor drug requires a prescription stating narcotic and amount, patient's name, room number, date, directions written in ink or with indelible pencil, and signature of licensed physician and Federal Narcotic Number.


Stock #195 HARRISON LAW DRUG SHEET

U.S. Reg. No. _____

NOTE: For every dose of Opium or Cocoa Leaves in any form, Opium, Morphine, Codiene, Laudanum, Heroin, Cocaine, etc, a full line of this sheet must be filled out. Not at some future time, but immediately when dose is given.

FAILURE TO DO SO IS PUNISHABLE UNDER THE LAW BY A FINE OR IMPRISONMENT OR BOTH!!

Date Day	Hour	Name	Location	Doctor	Drugs	Amt.	Administered By

Total Used _____

Tablets Rec'd _____

Signed _____

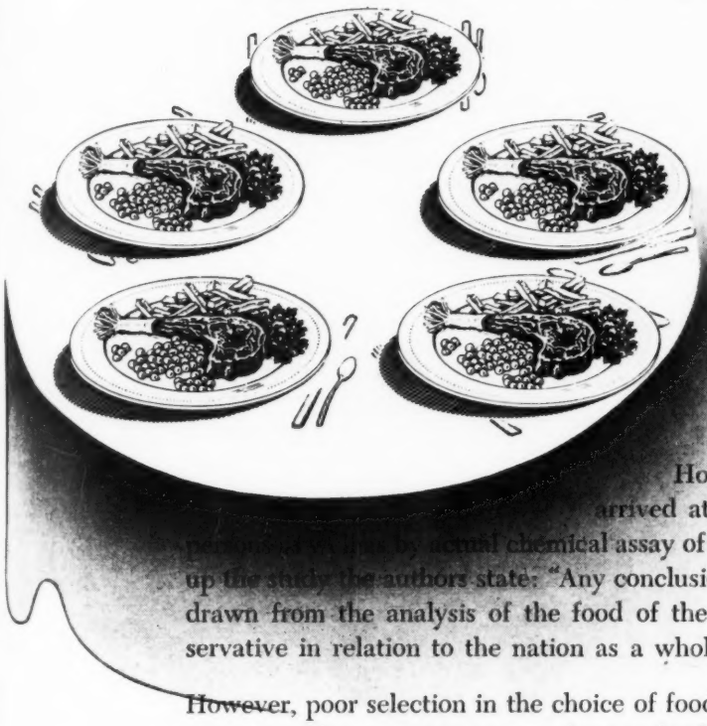
Date _____

Fig. 1—Narcotic law drug sheet is filled in on each floor. There is a separate sheet for each drug, and no refills are made until the sheet is completely filled in.

An entry sheet for the monthly report is kept on all narcotics purchased and used. This report serves as a perpetual inventory. (Sample entry sheet attached.) By dispensing narcotic floor drugs in bottles of twenty-five tablets each, we simplify the pharmacy inventory. The physician and registered nurse realize the necessity of a rigid control of narcotics and the pharmacy has their cooperation.

The Michigan Dangerous Drug Act No. 204 P.A. of 1943 (amended 1945) regulates the sale and possession of the

*only 21 per cent of persons consuming average diets obtain protective quantities of vitamins.**



Were this serious indictment of four out of five menus based on supposition it might well be questioned. However, it is not conjecture, but has been arrived at by analysis of recorded diets of 3336 persons and verified by actual chemical assay of the dietaries of 71 persons. In summing up the study the authors state: "Any conclusions as to the deficiencies present, when drawn from the analysis of the food of the test group, may be regarded as conservative in relation to the nation as a whole."

However, poor selection in the choice of food is only one factor contributing to this situation. The vitamin content of many foods as prepared for consumption is often considerably less than the vitamin content when first produced.

Handling of vegetables and fruits in picking, storing, packing and shipping frequently reduces vitamin content. As much as eighty per cent of ascorbic acid and ninety per cent of thiamine may be lost through overcooking or prolonged soaking.

While careful selection and preparation of vitamin-rich foods will offset some of the hidden factors operating to curtail adequate vitamin intake, the more practical physician will wish to supplement those diets which possibly may be faulty.

Parke-Davis VITAMINS

More than thirty-one years' experience in discovery, standardization and development lies behind the Parke-Davis vitamins the physician prescribes today. Whenever oral or parenteral vitamin therapy is indicated, one or more Parke-Davis preparations can be readily selected to fit individual needs.

*Lockhart, E. E.; Harris, R. S.; Tapia, E. W.; Lockhart, H. S.; Nutter, M. K.; Tiffany, V., and Nagel, A. H.: J. Diet. Assn. 20:742 (Dec.) 1944.

PARKE, DAVIS & COMPANY • DETROIT 32, MICHIGAN

MEDICAMENTA VERA

Date	R-X-Number	Patients Name or Mfg.	Used	Balance

Fig. 2—The hospital pharmacist delivers narcotics to registered nurses only.

following drugs: barbituric acid and any of its derivatives, chloral hydrate or paraldehyde. Sect. 1—(C) states that druggists and pharmacists shall be prohibited from selling, giving away, bartering or otherwise disposing of barbituric acid and any of its derivatives, chloral hydrate or paraldehyde, except on prescription of a licensed physician, dentist or veterinarian, and except as such sale or possession is authorized under subdivision (a) of this section. It shall be the duty of all druggists and pharmacists to keep an accurate record of all disposals, which record shall be open to inspection by any officer of any organized police force of this state or any prosecuting attorney or his investigators. (Michigan Laws Pertaining to Pharmacy, Compiled August 1, 1945.)

The aforementioned Michigan Dangerous Drug Act as written may not apply to other states. Some states may have a large number of drugs classified as dangerous drugs and may have a much more rigid Barbiturate and Dangerous Drug Act than Michigan has. The hospital administrator or pharmacist of another state should request information of his board of pharmacy if he does not have a copy of this law available. In using this system, he should make the necessary changes to comply with the law.

Barbiturates and their control have caused much concern to boards of pharmacy, drug inspectors, and law enforcement agents of most states. The increase in use of barbiturates by addicts has caused considerable alarm. Newspapers refer to barbiturates in different terms, such as "Red Devils," "Yellow Jackets," "Goof Balls," and "Phenos." Several states have barbiturate laws with teeth in them and our own Michigan Law should be revised to make the penalty more severe for those who violate it. There should be a rigid federal law pertaining to barbiturates which would be enforced by the federal government. The penalty for violation of this law should be as severe as that of the "Harrison Act." In many states barbiturates are too easily obtained. Barbiturates definitely have a therapeutic value when administered according to the directions of a physician.

After trying several systems, Hurley Hospital pharmacy devised a system in 1945 to keep an accurate record of all barbiturates dispensed by the pharmacy, which, though simple, complies with the Dangerous Drug Act.

Phenobarbital, seconal, nembutal, amytal tablets and carbrital capsules were recommended by the medical staff to be carried as floor stock. These barbiturates are dispensed in bottles of twenty-five each. The same procedure is followed by the floors in obtaining barbiturates as is followed in obtaining narcotics. Each floor keeps a "Barbiturate Record" sheet, entering each barbiturate administered. This sheet also is spaced for twenty-five entries. When all entries are completed, a registered nurse may sign and replace this barbiturate at the pharmacy. Barbiturates are delivered to a registered nurse only, never to a student nurse, orderly or auxiliary personnel. (See figure 3.) Any barbiturate not classified as a floor drug may be obtained for a patient from the pharmacy, on a prescription written in ink or with indelible pencil giving barbiturate and amount, date, patient's name, room number, directions and signature of a licensed physician.

The medical staff, physicians and pharmacy staff have cooperated to the full in the enforcement of the Act. Our administrator is especially interested in the enforcement of the Harrison Act and the Dangerous Drug Act and we have his complete cooperation. Any irregularities should be immediately reported to the administrator.

The same procedure is used for the monthly report of barbiturates as is used for narcotics. This system is equally as effective and practical for the larger hospital with a pharmacy as it is for the smaller hospital. Making entries daily takes little of the administrator's or pharmacist's time and gives the hospital absolute control and an accurate check of barbiturates used. It also simplifies checking and saves

HURLEY HOSPITAL
Stock #142 FLINT MICHIGAN

HOSPITAL BARBITURATE RECORD

Floor _____ Date Issued _____ 19 ____

PHARMACY:
The following is a record of the use of twenty five (25) _____

FAILURE TO DO SO IS PUNISHABLE UNDER THE LAW

Date Day	Date Hour	Name	Location	Doctor	Drugs	Amt.	Administered By

Total Used _____
Tablets Rec'd _____
Date _____

RECEIVED OF THE PHARMACY BY _____ R.N.
Assistant-Supervisor-Head Nurse

NOTE: Record all lost items as "LOST" with the name of the nurse losing same. EACH OF THESE MUST BE SUPPORTED BY AN AFFIDAVIT AND ATTACHED HERETO.

Fig. 3—Rules in regard to barbiturates are identical with those for narcotics. Five stock items are kept on the floor.

considerable time for federal narcotic agents and state drug inspectors in their inspections. After we installed this system, the consumption of barbiturates in Hurley Hospital was reduced 60 per cent.

Our procedure has been approved by the director of drugs and drugstores for Michigan and I have never hesitated to consult with him and with the state drug inspectors and federal narcotic agents on problems pertaining to drug laws and pharmacy and have always found them helpful and cooperative.

NOTES AND ABSTRACTS

Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

MYANESIN

MYANESIN is a comparatively new drug with a unique type of pharmacological action. Experimental work done on the compound thus far has shown that it may prove to be of great interest to the research worker and to the clinician.

History: Berger and Bradley, working at the British Drug Houses, first reported on the actions of myanesin in 1946. There have been other compounds, however, reported in the literature at various times, that have had actions resembling those of myanesin. Probably the earliest of these was coniine, an alkaloid found in the Water Hemlock, the poison which was reputed to have killed Socrates.

SIMILAR TO MYANESIN

In the years 1909-1910, various French workers described the actions of phenoxypropandiol, a compound structurally quite similar to myanesin. It produced a flaccid paralysis, hypothermia and analgesia in animals and was employed clinically by the oral route. Louis Goodman, in 1943, reported upon the properties of a drug called benzimidazole. The pharmacodynamics of benzimidazole are not unlike those of myanesin.

Chemistry: Myanesin is the orthotolyl ether of glycerol. Its chemical name is 3(orthotololyl)-1,2,propandiol. It is a colorless, odorless, crystalline solid, with a melting point of 70°C. Its solubility is only about 1 per cent in distilled water, but supersaturated solutions can be made with heating. Solubility is increased by the addition of urea derivatives, alcohol, or propylene glycol. The drug is stable to high temperatures, can be sterilized, and is compatible in solution with glucose, saline and the barbiturates.

Actions in animals: In the various laboratory animals, myanesin has proved effective by almost every route of administration. The subcutaneous dose is about five times the intravenous dose, and seven times the amount given by vein must be administered orally for a comparable effect. Obviously, the duration of action by the oral route is much longer than that by the intravenous. In the usual

paralyzing doses, myanesin produces loss of the righting reflex, a flaccid paralysis, and analgesia, as shown by the loss of the flexor withdrawal response. The knee jerk and corneal reflexes remain intact except with near lethal doses of the drug.

Immediately before the onset of the paralysis and often after its termination, there appears a peculiar decerebrate type of rigidity, which is most marked in the forelimbs and head. The lower limbs and abdominal muscles exhibit the most marked relaxation, are affected first, and recover after the upper regions of the body. Although difficult to evaluate, consciousness does not seem to be markedly disturbed. The paralyzing dose in animals when given intravenously over periods of from one to two minutes varies from 75 to 100 mgm/kgm.

Mode of action of myanesin: As we have already seen, myanesin produces a flaccid type of paralysis. Such an effect may be due to a depressant action on one or all of the following mechanisms: the muscles themselves, the myoneural junction (curare-like action), the peripheral nerves, the anterior horn cells or their connections, and various centers in the brain stem. One, of course, cannot exclude an additional action on the cerebral cortex, a well known property of the various anesthetic drugs.

Action on the muscles, myoneural junction, and peripheral nerves: When administered to frogs in both paralyzing and lethal doses, there is no depression of the ability of the muscle to contract when it or its nerve is electrically stimulated. This indicates that when one paralyzes animals with myanesin, there is no depression of the muscle itself, no curare-like activity at the myoneural junction, and no peripheral nerve depression.

It is interesting to note, however, that Berger and others have shown that myanesin has local anesthetic properties of the order of procaine when applied topically on the rabbit cornea and when injected subcutaneously in the guinea pig. It is also as potent as procaine in depressing the *in vitro* peripheral nerve preparation. The concentrations and time required to do this, however, are never realized in the intact animal. We must therefore look elsewhere for the site of action of myanesin.

Action on the spinal cord: Mice treated with lethal doses of tetanus toxin and then allowed to develop typical seizures have been treated with myanesin. Paralyzing doses of the drug completely prevented convulsions during the time of paralysis. Death, however, is evidentally not prevented by myanesin.

PREVENTS CONVULSIONS

Myanesin is capable of preventing both convulsions and death caused by strychnine. The relative effect of myanesin in ameliorating convulsions caused by strychnine and those caused by metrazol or electric shock shows that the drug has a greater selectivity in its action on the convulsions caused by strychnine than on those caused by metrazol or electric shock.

It is also of interest to note that the clonic phases of the latter two methods are as severe or more severe than the controls, and that the tetanic or tonic phases are made less noticeable or completely disappear. These effects suggest a selectivity of action on centers below the cortex and that the rapid-fire impulses producing tonic convulsions are suppressed at subcortical levels. These actions are seen with doses of myanesin that do

not have any visible effect upon the normal animal.

Action on the cerebral cortex: We have pointed out that myanesin has no selectivity of action on the cerebral cortex. Further evidence for a lack of predominant cortical effect is derived from the clinical observations that there is no sedation, no anesthesia, and no loss of voluntary muscle power when clinical doses are used. In animals, furthermore, there is no pre-anesthetic excitation.

Action on the brain stem: There are certain evidences which point to an action of myanesin on the brain stem. One is the production of nystagmus. Schlesinger uses this sign as an end-point in intravenous infusion of the drug. The action may be due to a direct effect on the labyrinthine pathways or to extra ocular muscle weakness, but in either case the action seems to lie within the brain stem.

Although Berger believes that the heretofore-described rigid state is caused by a direct action on skeletal muscle, it is probable that the effect is produced by a functional ablation of the centers above the pons, such as one can produce mechanically with a scalpel. The fact that animals can be flaccidly paralyzed with persistence of the knee jerks suggests a lack of predominant action on the primary reflex arcs. In large doses, myanesin depresses respiration, indicating an action on the medullary centers.

Other actions of the drug: In the intact animal the administration of paralyzing doses of myanesin produces few side effects. The effects that are seen rather consistently are nystagmus, decerebrate-like state, slowing of the respiration and slowing of the heart rate. Seen at various times are salivation and lachrymation, vomiting in dogs, and dilatation of the pupils in cats. When myanesin is given intravenously in solutions of greater than 2 per cent concentration, it produces hemolysis of red blood cells and thrombophlebitis. This factor limits the usefulness of the drug because of the danger of producing hemoglobinuria. The drug is effective orally, however, and since hemolytic effects have not been seen when the drug is orally administered, myanesin is entirely safe in this respect when given by mouth.

PRODUCES DEPRESSIVE EFFECTS

In the acutely ill dog, all of the side effects seen are potentiated by barbiturate anesthesia. Myanesin produces depression of the blood pressure, pulse and respiration. None of these effects is blocked by atropine. In near lethal doses myanesin depresses the sino-atrial node, atrio-ventricular conduction, and ventricles, so that lethal doses given rapidly intravenously are likely to stop the heart as well as respiration. The respiratory effect probably results from depression of the medulla. The blood pressure fall may be due to a pooling of blood in the relaxed muscles, a specific effect on the blood vessels, a depression of the spinal centers, or to a combination of these effects.

Although it has been reported that myanesin is capable of producing hypothermia, it is probable that this effect does not occur to any noticeable degree unless full paralyzing doses are given. There seems to be no demonstrable effect on the gastrointestinal tract. Berger has shown that there is no effect on blood sugar. It is of interest to note that when animals are killed with myanesin, they do not exhibit anoxic convulsions, as do animals

given lethal doses of curare. Prostigmine has little effect on respiratory depression due to myanesin, but metrazol seems to be a good stimulant.

Metabolism and fate of myanesin: The effects of myanesin are short lasting and the intravenous dose can be increased markedly by giving the injection over longer periods of time. These suggest that the drug undergoes rapid metabolism. By nitrating myanesin in aqueous solution, Wyngaarden, Woods and Seevers have devised a color test for myanesin. These workers showed that after intravenous injections in dogs myanesin disappeared rapidly from the blood stream.

It is evidentally detoxified in the liver, being partially oxidized to the propionate (Graves, Elliot and Bradley), partially conjugated, and excreted as the free substance in the urine in a very small amount. The propionate and conjugate also appear in the urine. Wyngaarden and his group believe that the conjugate is probably glycuronic acid.

The conjugation product, but not free myanesin, gives a red color with Ehrlich's diazo reagent, so that the urine of clinical patients can be tested for the excretion product. Morrison, Richardson and Walker have shown that myanesin is evenly distributed in the body fluids.

Differences from curare: Although there are numerous minor differences between the two drugs, three major comparisons can be drawn between myanesin and curare. First, myanesin possesses no curare-like activity at the myoneural junction. Second, myanesin is effective orally, thus possessing a decided clinical advantage over curare. Third, myanesin has a great margin of safety as compared with curare, because it can produce complete paralysis without stopping the respiration. Also, the doses that are used clinically represent about one tenth the full paralyzing amounts of the drug.

Preparations and doses: It is available in sterile 10 per cent solutions in ampules (British Drug Houses), in a crystalline powder, and in 0.25 gram tablets (Tolserol, Squibb). The oral dose usually is between 1 and 2 grams. The intravenous dose is quite variable, being approximately 15 to 30 mgm/kgm. of body weight.

Clinical uses: Because of its oral effectiveness and ability to diminish muscle hyperkinesis and spasm in doses that will not affect normal individuals, myanesin has enjoyed a rather wide clinical application. Like curare, it has the advantage of providing the clinician with a conscious and cooperative patient.

TO OBTAIN MUSCULAR RELAXATION

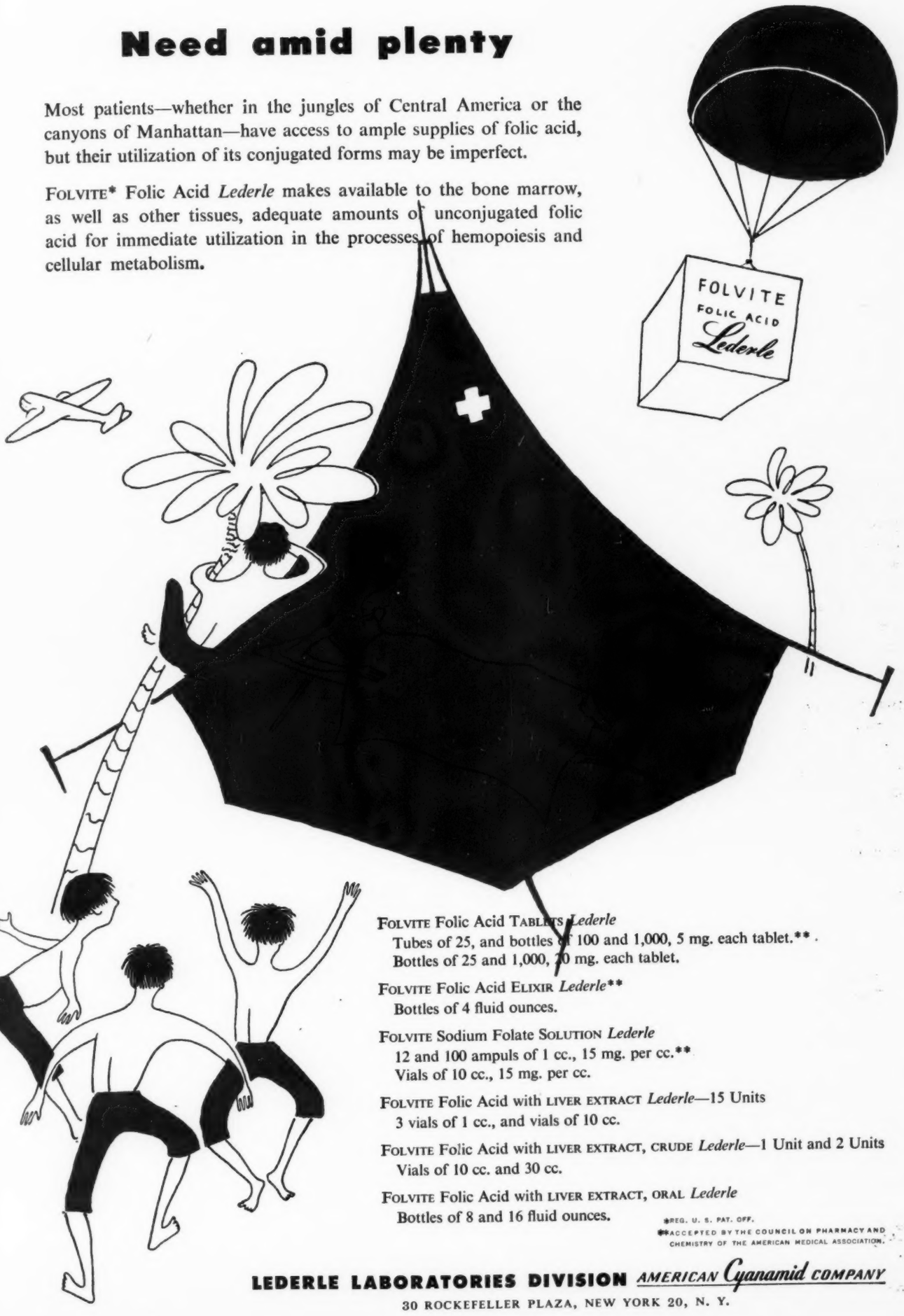
Mallinson first used the drug clinically to obtain greater muscular relaxation during anesthesia. Schlesinger, Drew and Wood, Berger and Schwartz, and also Stephen and Chandy subsequently reported that myanesin relaxes the muscles of patients with hemiplegia and spastic paralysis. parkinsonism and other extrapyramidal diseases, acute muscle spasms due to arthritis and bursitis, and that it is of value in the treatment of congenitally spastic children.

Belfrage has reported a case of tetanus treated with avertin and myanesin, and Hunter and Waterfall report successful therapy with myanesin of some cases of both organic and idiopathic epilepsy. The drug seems to have a rather specific effect on parkinsonism and related disorders.—ARNOLD H. KAPLAN and KLAUS R. UNNA, M.D.

Need amid plenty

Most patients—whether in the jungles of Central America or the canyons of Manhattan—have access to ample supplies of folic acid, but their utilization of its conjugated forms may be imperfect.

FOLVITE* Folic Acid *Lederle* makes available to the bone marrow, as well as other tissues, adequate amounts of unconjugated folic acid for immediate utilization in the processes of hemopoiesis and cellular metabolism.



FOLVITE Folic Acid TABLETS *Lederle*
Tubes of 25, and bottles of 100 and 1,000, 5 mg. each tablet.**
Bottles of 25 and 1,000, 10 mg. each tablet.

FOLVITE Folic Acid ELIXIR *Lederle***
Bottles of 4 fluid ounces.

FOLVITE Sodium Folate SOLUTION *Lederle*
12 and 100 ampuls of 1 cc., 15 mg. per cc.**
Vials of 10 cc., 15 mg. per cc.

FOLVITE Folic Acid with LIVER EXTRACT *Lederle*—15 Units
3 vials of 1 cc., and vials of 10 cc.

FOLVITE Folic Acid with LIVER EXTRACT, CRUDE *Lederle*—1 Unit and 2 Units
Vials of 10 cc. and 30 cc.

FOLVITE Folic Acid with LIVER EXTRACT, ORAL *Lederle*
Bottles of 8 and 16 fluid ounces.

*REG. U. S. PAT. OFF.
**ACCEPTED BY THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION.

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30 ROCKEFELLER PLAZA, NEW YORK 20, N. Y.

FOOD SERVICE

Conducted by Mary P. Huddleson

TRENDS IN DIET THERAPY

DORIS JOHNSON
Dietitian
Presbyterian Hospital
New York City

THE trend in diet therapy for the past few years has been toward fewer and better diets. Fewer diets have been brought about by unification and simplification of similar diet procedures. Instead of a diet for every disease, the trend is to have a diet which has certain therapeutic principles that can be applied with only slight modification to a number of different diseases. This is true, for example, of either the bland diet or the high caloric diet.

SHE CAN PLAN BETTER DIETS

The planning and preparation of fewer kinds of therapeutic diets allow the dietitian to plan better diets and give her more time to see that the diets are acceptable to the patients. This means visiting the patients regularly and conferring with them about their diets, which affords the dietitian an opportunity to teach the patients about their diets, as well as to learn about their likes and dislikes and to plan the diets to conform as nearly as possible to their eating habits.

Therapeutic dietitians should not become so involved in desk routines that they do not have adequate contact with the patients. All the diet therapy in the world is of little value in the treatment of the patient if he does not *eat* the food. Often the personal contact with the patient is the determining factor in whether a patient will or will not accept a diet.

If we are to have fewer and better diets it means that we must be adaptable to changes in therapy as new information is given to us. The ketogenic diet, for example, is now mainly of historical interest. Perhaps there are other therapeutic practices which can be eliminated or modified in the light of present teaching and in the interest of the patient.

The soft diet and its variations can be made more liberal in many instances. Many fruits and vegetables, such as peaches, pears, carrots and asparagus tips, for example, if carefully prepared, are low enough in cellulose to be served whole on soft and low residue diets. Meats, too, if they are tender and well prepared, need not always be ground. Flaking fish in many instances is entirely unnecessary. The bland diet also can allow such modifications when the patient is sufficiently improved to warrant it.

The report of the American Dietetic Association meeting in Boston will be found on Page 138 in the news section

Many hospitals no longer use high vitamin or high mineral diets as therapeutic measures. It is realized that high vitamin or high mineral intakes are more easily obtained, at less cost and with greater satisfaction to the patient, by the use of medications rather than by eating sufficient amounts of foods in order to obtain therapeutic amounts of vitamins or minerals.

The diabetic diet is another one that can well be modernized and standardized. Such an attempt is being made now. The American Dietetic Association and American Diabetes Association are preparing a simplified classification of the foods used in calculating the diabetic diet in an attempt to simplify and standardize it. At the 1947 annual meeting of the American Dietetic Association the following tentative classification of foods was proposed:

The vegetables usually classified from 3 to 9 per cent carbohydrate are placed in one group and given the value of 5 per cent carbohydrate. Vegetables of less than 3 per cent carbohydrate, such as the salad greens, cucumbers and radishes, are allowed *ad lib.* Fruits are calculated in portions equal to 15 grams carbohydrate. Breads, cereals, crackers, potatoes, lima beans, peas and other high carbohydrate vegetables are also calculated in portions equal to 15 grams carbohydrate. One pint of milk has the carbohydrate value of 25 grams. Meat or its equivalent has a value of 7 grams protein and 5 grams fat for each 30 grams, while 5 grams of butter or its equivalent has the value of 4 grams fat.

CLASSIFICATION OF FOODS

This is a tentative proposal for the classification of the foods used in calculating the diabetic diet, and its final adoption, with any necessary modifications, will follow adequate trial by a representative number of people. Such a classification should lead to much easier planning of diets and teaching of patients, nurses, medical students, and medical and dietetic interns.

The use of special foods and complicated recipes for the preparation of diabetic diets is also becoming obsolete. Since the diabetic diet so nearly approaches the normal diet in

Plan for Diet Containing Approximately 225 Milligrams Sodium

DAILY ALLOWANCE OF FOOD** Food	Amount	Weight Grams	Protein Grams	Calories	Sodium* Milligrams
Fruit (List 1)	3 servings	300	...	145	3.01
Vegetables (List 2)	2 servings (½ c.)	100	4	65	10.68
Bread, without salt	2 slices	60	6	155	28.20**
Butter, sweet	2 tablespoons	...	...	240	1.50
Cereal, dry weight (List 3)	1 serving	20	2	70	.08
Potato, etc. (List 4)	2 servings	200	2	170	3.00
Egg	1	50	7	80	70.00
Meat (List 5)	5 ounces	150	36	330	106.00
Sugar	1 tablespoon	15	...	60	.....
Jam or honey	3 tablespoons	45	...	120	3.15
Low sodium milk, reconstituted	2 cups	480	16	290	6.00
Total		...	73	1725	231.62

Reference: Tables of Food Composition in Terms of Eleven Nutrients, U.S. Department of Agriculture Miscellaneous Publication No. 572, 1945.
*Figures taken from Mead Johnson and Company. List, May 1947.
**Figure obtained from manufacturer.
***All foods are prepared without salt, soda or baking powder.

LISTS OF FOODS ALLOWED

LIST 1—FRUITS

0.97 mgs. Sodium per 100 grams, average
0.1—4.0 mgs. per cent, range
Apricots
Avocados
Bananas
Blackberries
Blueberries
Cranberries
Dates
Grapes
Grape Juice
Grapefruit
Grapefruit Juice
Oranges
Orange Juice
Pears
Persimmons
Pineapple
Plums
Raspberries
Strawberries
Tangerines

LIST 2—VEGETABLES (Fresh or Frozen Only)

5.84 mgs. Sodium per 100 grams, average
0.2—24.0 mgs. per cent, range
Beans, string
Beans, lima
Broccoli
Brussels sprouts
Cabbage
Cauliflower
Corn, sweet
Cucumber
Eggplant
Endive
Mushrooms
Okra
Onion
Parsnips
Peas
Squash, all kinds
Rutabages

LIST 3—CEREALS

0.08 mgs. Sodium per 120 grams, average
0.8—3.0 mgs. per cent, range
Ralstons
Pettijohns
Wheatena
Farina
Puffed rice
Rice
Puffed wheat
Shredded wheat
Oatmeal

LIST 4—POTATO OR SUBSTITUTE

1.50 mgs. Sodium per 1 serving, average
0.2—4.0 mgs. per cent, range
White potato, 100 grams
Sweet potato, 100 grams
Macaroni, dry, 20 grams
Spagetti, dry, 21 grams

LIST 5—MEATS

71.00 mgs. Sodium per 100 grams, average
53.00—110.00 mgs. per cent, range
Beef
Chicken
Cod, fresh
Heart
Liver
Pork
Veal

the foods allowed there is no need for specially prepared dishes. The diabetic patient should not, of course, use foods having a large amount of free carbohydrate, but he can have cereals, bread, fruits, vegetables and milk for his carbohydrate allowance.

The use of prepared dishes makes for greater difficulty in planning the diet and in the teaching of the patient. It also makes it more difficult for the patient to learn to do without concentrated carbohydrate foods and leads to greater inaccuracies in food intake. The sooner the diabetic patient learns to do without concentrated sweets, the better off he will be. It is felt by some clinicians that the avoidance of these concentrated carbohydrate foods leads to better control of the diabetic patient with fewer complications.

Early ambulation of surgical patients has brought about earlier postoperative feeding. It is not uncommon to have patients with appendectomies and other uncomplicated operations eating a regular diet by the evening of the first day after operation. It will be interesting to see whether this earlier postoperative feeding will decrease the incidence of the complication of distension which is so common after operation. Some of the more extensive surgical procedures of the gastrointestinal tract, however, still require more conservative treatment. There is a trend toward allowing the patient who has had a gastric resection to have a soft diet in six small feedings rather than a bland diet, such as he had before the operation and which did not prevent the need for surgery. It is felt that the psychological effect of allowing the soft diet in six feedings, although it is not too different from the bland diet, will do much in the rehabilitation of the patient. He will feel that something was accomplished by surgery. Whereas, if he returned to the bland diet, a feeling of the needlessness of the surgery occurs, and in many patients this leads to discouragement.

For some years now the feeding of increased amounts of protein preoperatively and postoperatively to burned patients or those with fractures and similar conditions in which there is trauma and nitrogen loss has been emphasized. The search for a protein hydrolysate that will be palatable so that unusually large amounts of protein can be ingested has not yet led to an entirely satisfactory product. Cannon has reported recently that all

protein hydrolysates are not of equal nutritional value, and only those that have been shown to be adequate in amino acid content should be used. Dried milk powders of various kinds with egg white added to milk have so far proved to be the most satisfactory high protein beverages for the majority of patients.

The treatment of the cardiac patient has also undergone some changes of late. A number of years ago reports in the literature emphasized the fact that fluids need not be restricted in cardiac edema as long as sodium was restricted. This was not practiced clinically until relatively recently when various clinicians employed this method of treatment. It was found that many cardiacs were really dehydrated in the presence of edema. By giving fluids and restricting salt this dehydration was overcome and a diuresis resulted. This procedure has been found most satisfactory where there has been renal damage.

Along with the restricted sodium intake some advocate either an acid or a neutral ash diet and acid medication, such as ammonium chloride. The acid or neutral ash diet is used to prevent neutralization of ingested acidifying diuretics and metabolic acids which mobilize already stored sodium.

The salt or, more specifically, the sodium restriction in the treatment of the cardiac patient with edema and in nephritis and nephrosis is particularly important and it is felt that the lower the sodium intake, the better the results obtained. The usual low sodium diet is about 750 to 1000 mgm. sodium per day. It is better if the sodium is kept below this amount when edema is present in order to bring about a loss of fluid.

A diet of about 200 mgm. sodium is indicated. When the edema has disappeared on such a diet a higher sodium intake may be allowed. To obtain a diet containing about 200 mgm. sodium it is necessary to select and measure the foods carefully. Milk cannot be used. Therefore such a diet will be inadequate in calcium and riboflavin. However, a low sodium milk which overcomes this deficiency has been devised for use on low sodium diets.

Hypertension has also been shown to respond to a very low sodium diet. The rationale for this is not yet known. However, a number of unusual low sodium diets have been evolved. These are usually inadequate nutritionally and not very appetizing. A low sodium diet can be planned which is adequate nutritionally, palatable and attractive to the patient and there is no need to subject him to a bizarre dietary regimen.

The low sodium, low caloric diet is used for pre-eclamptic patients on the same basis that it is used for the cardiac patient with edema. The diet should also be high protein since low serum proteins are associated with the pre-eclamptic state.

The diet for the treatment of diseases of the liver has also been undergoing modification. For infectious hepatitis a high protein, high caloric diet without fat restriction has been found effective. The need for an adequate caloric intake plus a sufficient protein intake to bring about tissue regeneration and supply extra amounts of methionine, the lipotropic amino acid, has been shown. The allowance of a normal amount of fat has been shown to promote a greater food consumption and, hence, a higher protein and higher caloric intake.

In cirrhosis of the liver, a high

protein diet for regeneration of tissue and supply of methionine is also extremely important. There must be regeneration of the liver tissue plus an extra supply of protein for the manufacture of serum proteins. The manufacture of serum albumin by the liver can then more nearly approach normal and serum proteins can increase with the resultant decrease in the ascites.

The diet should be high in carbohydrate for its protein-sparing action and good glycogen supply. The level of fat intake, as long as it is not excessive and comes from highly emulsified fat, seems to make little difference but, on the contrary, makes for better food consumption.

Evidence has shown that more rapid healing of peptic ulcer is accomplished with a higher protein intake. From 175 to 250 grams of protein have been recommended. Besides supplying protein for better nutrition and tissue repair, the increased amounts of protein are effective antiacids. Protein hydrolysates have been employed in some instances to bring about this increased protein intake.

We could mention still other changes in diet therapy. As an integral part of the medical sciences, diet therapy progresses with the newer findings in medicine. We must all keep abreast of the times and adapt our practices to the most recent accepted principles. We must be willing to discard obsolete ideas, to simplify as many diets as possible and to make the ones we use the best possible.

Close contact with the doctor and with the patient is an important asset in good diet therapy. Regular attendance on doctors' rounds, with participation in the discussion of the patient's care, should be a regular part of every therapeutic dietitian's day. We can learn much but we can also offer much, and many doctors appreciate and expect suggestions from us, the dietitians, since many of them are not versed in the practical aspects of diet therapy. We can do much to increase the esteem of the medical profession for dietitians by the intelligent application of our knowledge, which we should be sure is always up to date.

FOOD FOR THOUGHT

Old Age and Nutrition

How the food people eat affects the characteristic changes of old age is a question now being studied by the California Experiment Station in cooperation with one county in that state and with state and federal agencies. About a thousand residents of this county who are 50 years or older and in apparent good health will be chosen to give their nutritional and medical history and receive examinations by physicians, biochemists, nutritionists and laboratory technicians.

The aim of the study is to explore the ills of elderly people and determine the relationship between health and nutrition; to learn how to correct nutritional deficiencies, and to aid elderly people to keep in the best possible health.

The results of the study may throw more light on what happens to people in aging and what the inevitable natural changes are in contrasts to changes caused by deficiency and degenerative diseases. As more scientific facts are gathered, people not only may live longer but may also remain more active and socially useful.

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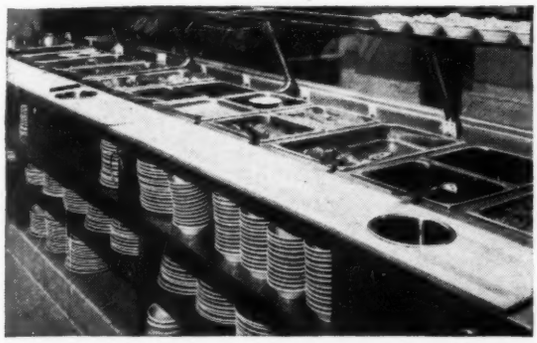
Yes, your own experiments with Ac'cent in your own recipes will be fun—and profitable too. For with Ac'cent, your own artistry is more completely expressed, and people will note how even good food well prepared can be made *more* enjoyable.



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Menus for December 1948

Helen Start
Barre City Hospital
Barre, Vt.

1
Pineapple Juice
Griddle Cakes, Sirup
•
Breaded Veal Chop With
Spiced Crabapples
Mashed Potatoes
Baked Squash
Orange and Grapefruit
Salad
Strawberry Bavarian
Cream
•
Consommé
Spaghetti Italienne
With Tiny Meat Balls
Stuffed Celery Salad
Baked Apples
Icebox Cookies

2
Apple and Apricot Juice
Scrambled Eggs, Bacon
•
Baked Ham With
Grilled Pineapple
Glazed Sweet Potatoes
Steamed Spinach
Apple, Raisin, Celery Salad
Angel Food
•
Cream of Asparagus Soup
Chicken Salad Sandwiches
Pickle Chips
Tomato Aspic Salad
Spanish Cream With
Chocolate Sauce

3
Oranke Sections
French Toast
•
Broiled Mackerel With
Lemon Sauce
Baked Stuffed Potatoes
Whole Kernel Corn
Perfection Salad
Lemon Pie
•
Vegetable Soup
Salmon Wiggle
Stuffed Prune Salad
Fresh Coconut Cake

4
Stewed Rhubarb
Crisp Bacon Strips
•
Spanish Steak
Parslied Potatoes
Broiled Tomatoes
Fresh Fruit Salad With
Whipped Cream Dressing
Filled Cookies
•
Okra Soup
Hamburgers and Rolls
Delmonico Potatoes
Tossed Green Salad
Blue Plums
Cookies

5
Half Grapefruit
Soft Cooked Eggs
•
Roast Chicken
Baked Potatoes
Steamed Broccoli
Celery, Cranberry Sauce
Raspberry Sherbet
•
Tomato Soup
Baked Macaroni With
Chipped Beef
Lettuce and Grated
Carrot Salad, French
Dressing
Frozen Peaches
Lady Fingers

6
Frozen Orange Juice
Oatmeal Muffins
•
Braised Liver and
Broiled Bacon
Creamed Potatoes
Julienne Green Beans
Sliced Tomato and
Pepper Ring Salad
Caramel Blancmange
Hermits
•
Cream of Celery Soup
With Croutons
Chicken Croquettes With
Mushroom Sauce
Combination Vegetable
Salad
Pineapple Chunkets
Angel Food

7
Stewed Prunes
Sausage Links
•
Swiss Steak
Snowball Potatoes
Creamed Cauliflower
Fruit Salad
Cottage Pudding With
Chocolate Sauce
•
Scotch Broth
Spanish Omelet
Buttered Asparagus
Celery and Olives
Boston Cream Pie

8
Tomato Juice
Poached Eggs
•
Pot Roast With
Brown Gravy
Hash Browned Potatoes
Harvard Beets
Pear and Orange Salad
on Watercress
Floating Island
•
Tomato Bisque
Oyster Soufflé
Dressed Lettuce
Pineapple Bavarian Cream
Peanut Butter Cookies

9
Grapefruit Juice
Popovers
•
Veal Stew With
Carrots and Onions
Boiled Potatoes
Green Spinach
Lettuce With
Russian Dressing
Prune Whip
•
Chicken Noodle Soup
Calico Hash
Chopped Lettuce and
Egg Salad
Graham Cracker Pudding

10
Stewed Pears
Date Muffins
•
Broiled Finnan Haddie
With Butter Sauce
Browned Potatoes
Stewed Tomatoes
Lettuce With Roquefort
Dressing
Apricot Whip
•
Cream of Mushroom Soup
Tomatoes Stuffed With
Crabmeat
Potato Chips
Dill Pickle
Applesauce
Fig Newtons

11
Prune Juice
Scrambled Eggs, Bacon
•
Shepherd's Pie With
Potato Topping
Buttered Carrots
Celery Curls
Coffee Gelatine With
Whipped Cream
•
Chicken Broth
Lamb Chops on
Toast Squares
Tossed Salad With
Thousand Island Dressing
Grapes
Icebox Cookies

12
Tangerines
Cinnamon Toast
•
Fricasseed Chicken
Parslied Potatoes
Green Peas
Celery Hearts,
Cranberry Relish
Banana Ice Cream
•
Mulligatawny Soup
Sandwich Plate:
Peanut Butter and
Marshmallow
Cream Cheese and
Pineapple
Waldorf Salad
Chocolate Fudge Cake

13
Grapes
Poached Eggs
•
Roast Lamb
Mashed Potatoes With
Brown Gravy
Baked Acorn Squash
Norwegian Apples
Spice Cake
•
Consommé Julienne
Spinach Soufflé With
Mushroom Sauce
Hot Parker House Rolls
Chocolate Pudding
Vanilla Wafers

14
Apple Juice
Sausage Patties
•
Meat Loaf
Creamed Potatoes
Steamed Cabbage
Pineapple and Cherry
Salad
Grapenut Custard
•
Vegetable Chowder
Asparagus on Toast
With Cheese Sauce
Cabbage, Carrot, Raisin
Salad
Date Tapioca Pudding

15
Grape and Orange Juice
Ham Omelet
•
Old Fashioned Chicken Pie
Mashed Potatoes
Brussels Sprouts
Stuffed Pear Salad With
Ginger
Sponge Cake
•
Oxtail Soup
Macaroni and Cheese
With Tomatoes and Bacon
Tossed Green Salad
Frozen Strawberries With
Whipped Cream

16
Half Grapefruit
Crisp Bacon
•
Hamburger Patties
Mashed Potatoes
Diced Rutabagas
Apple Brown Betty
Caramel Brownies
•
Julienne Soup
Poached Eggs in Potato
Nests
Green Peas
Carrot Sticks
Lemon Snow Pudding
With Custard Sauce

17
Grapefruit Sections
Bran Muffins
•
Baked Stuffed Haddock
With Lemon Wedges
Parslied Potatoes
Fresh Spinach
Orange Sherbet
Gingersnaps
•
Split Pea Soup
Tuna Salad
Potato Chips
Sliced Tomatoes
and Swiss Cheese
Coffee Spanish Cream

18
Prune Juice
Soft Boiled Eggs
•
Broiled Lamb Chops
Oven Browned Potatoes
Buttered Peas and Carrots
Chocolate Blancmange
•
Consommé
Club Sandwich
Deviled Egg Salad
Graham Cracker Pudding

19
Pineapple Juice
Coffee Rolls
•
Broiled Sirloin Tips
With Mushrooms
Baked Stuffed Potatoes
Cauliflower
Radish Roses
Strawberry Sundae
•
Beef Broth
Tomato Rabbit
Jellied Fruit Salad
Brownies

20
Stewed Rhubarb
Crisp Bacon
•
Roast Veal With Dressing
Hash Browned Potatoes
Harvard Beets
Celery Sticks
Grapes
•
Oyster Stew With Croutons
Cheese and Crackers
Cranberry and Orange
Salad
Chocolate Ice Cream

21
Stewed Apricots
Sausage Links
•
Salisbury Steak
Baked Potatoes
Green Beans in Cream
Shredded Lettuce With
French Dressing
Apple Pandowdy
•
Tomato Bouillon
Flannel Hash
Julienne Vegetable Salad
Sliced Oranges With
Custard Sauce

22
Orange Juice
Scrambled Eggs
•
Broiled Ham Slices
Parslied Potatoes
Mashed Turnips
Pineapple Salad
Peppermint Stick Ice
Cream
•
Tomato Bisque
Chicken Chow Mein and
Noodles
Carrot and Raisin Salad
Sliced Peaches
Sponge Jelly Roll

23
Apple Juice
Cornmeal Muffins
•
Veal Birds
Mashed Potatoes
Lima Beans
Sliced Tomatoes With
French Dressing
Rice Pudding
•
Vegetable Chowder
Escalloped Potatoes
With Grilled Bologna
Frozen Asparagus
Rhubarb
Wafers

24
Stewed Prunes
Poached Eggs
•
Turbot
Parslied Potatoes
Diced Beets
Tossed Vegetable Salad
Cottage Pudding With
Lemon Sauce
•
Consommé Julienne
Salmon Loaf
Baked Potatoes
Relish
Kadota Figs
Icebox Cookies

25
Half Grapefruit
Bacon, Eggs
•
Cranberry Punch
Roast Turkey
Sweet Potatoes
Peas, Boiled Onions
Hot Parker House Rolls
Lettuce, Thousand
Island Dressing
Mince Pie, Cheese
•
Mulligatawny Soup
Chicken Salad Sandwich
Fresh Fruit Salad
Vanilla Ice Cream
Christmas Cookies

26
Tangerines, Grapes
Crisp Bacon
•
Roast Lamb
Baked Stuffed Potatoes
Baked Squash
Cranberry Gelatin Salad
Pineapple Upside-Down
Cake
•
Turkey à la King on
Baking Powder Biscuits
Jellied Vegetable Salad
Orange Sherbet

27
Orange Sections
Egg Omelet
•
Broiled Liver and Bacon
Pan Browned Potatoes
Creamed Lima Beans
Waldorf Salad
Brownies
•
Split Pea Soup
Creamed Chipped Beef
on Toast Points
Tomato and Lettuce
Salad
Raspberry Tarts

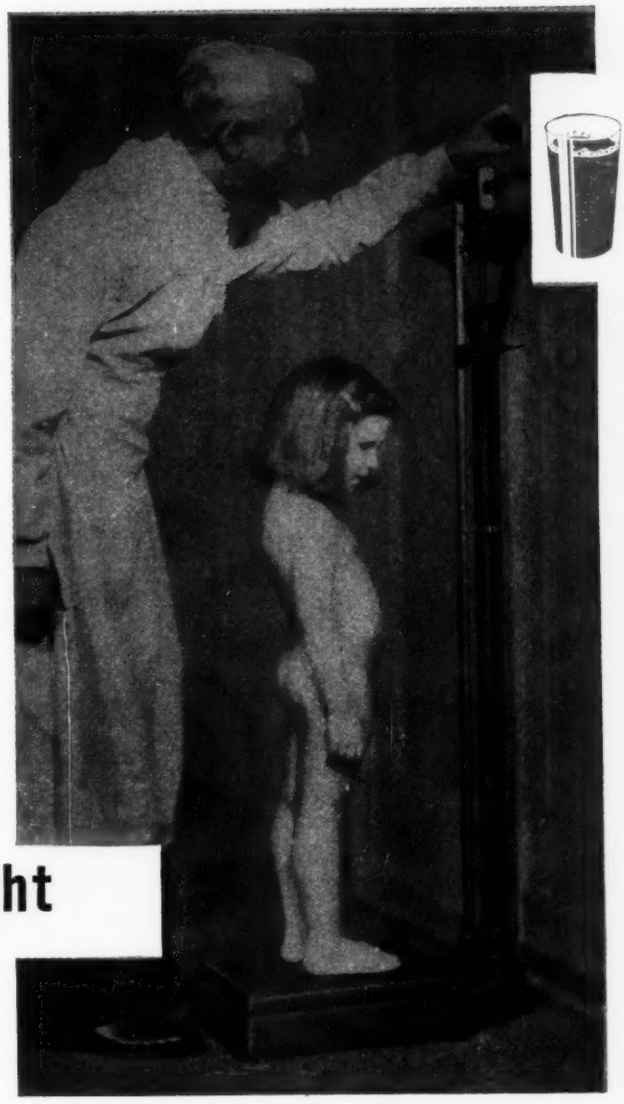
28
Baked Apple
Soft Boiled Eggs
•
Canadian Bacon
Mashed Potatoes
Spiced Peach
Glazed Carrots
Strawberry Sundae
•
Tomato Julienne Soup
Cold Cuts
Potato Salad
Pickle Chips
Hot Cloverleaf Rolls
Coconut Custard

29
Orange Juice
Eggs and Bacon
•
Fricasseed Chicken
Candied Sweet Potatoes
Green Asparagus
Orange Ambrosia
•
Consommé
Cheese Rabbit With
Minced Ham
Lettuce With French
Dressing
Sliced Pineapple
Oatmeal Cookies

30
Grapefruit Juice
Waffles With Sirup
•
Veal Stew
Boiled Potatoes
Fresh Spinach
Stuffed Apricot Salad
Banana Nut Pudding
•
Hungarian Goulash
Jellied Fruit Salad
Prune Whip
Wafers

31 Fresh Pineapple, Egg Omelet • Broiled Sword Fish, Baked Potatoes, Succotash, Tossed Chef's Salad, Gingerbread With Whipped Cream • Shrimp Wiggle on Toast, Asparagus Tip Salad, Spiced Pears, Angel Food

Ready-to-eat or cooked cereals are offered on all breakfast menus.



citrus fruits and juices... worth their weight in gold!

Few foods pay such bountiful dividends in nutritional supply, psychological stimulus and sensory pleasure as do citrus fruits. Their great variety of essential nutrients,* highlighted by a remarkable abundance of vitamin C (prerequisite for tissue health and vigor[5]), with rich fruit sugars for quick energy release,[3] recommend their liberal inclusion in the hospital dietary.

Mildly laxative,[4] systemically alkalinizing,[3] and markedly beneficial in the management of chronic infectious conditions,[2] citrus fruits are also instrumental in bettering calcium utilization,[1] and in combatting anorexia.[3] Generous daily servings of Florida citrus fruits and juices — fresh or canned — can help save time and money in speeding convalescence!

FLORIDA CITRUS COMMISSION • LAKELAND, FLORIDA

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Citrus fruits and juices are among the richest known sources of vitamin C; they also contain vitamins A, B_1, G and [illegible], and other nutritional factors such as iron, calcium, citrates, citric acid and readily assimilable fruit sugars.

FLORIDA Oranges • Grapefruit Tangerines

MAINTENANCE AND OPERATION

CONDITIONED AIR CUTS CROSS-INFECTIONS

in children's hospitals

GUSTAF BIRCH-LINDGREN
Architect
Stockholm, Sweden

ONE of the most important considerations in planning children's hospitals is the prevention of cross-infections as far as possible. Investigations carried out in 1935 at the Crownprincesse Lovisa Children's Hospital in Stockholm have shown that for the period 1926-1933 the average stay in the hospital for a normal case was 29.5 days, but that this period increased to 52.2 days if the patient contracted some new infection in the hospital in addition to his original complaint. This was the case with about 30 per cent of the patients.

Even when, as in more recent years, the average stay at this hospital has been shortened considerably, the relative figures remain about the same. It must be borne in mind that apart from the additional risk to the patient resulting from the contraction of a new disease, there is also the economic aspect to be considered, since it will cost at least twice as much to cure the patient and perhaps considerably more. This can be expressed in another way by saying that if cross-infection can be prevented, a smaller number of beds can handle the same number of patients.

When planning children's hospitals, there are two kinds of cross-infection to be considered: through direct contact and through the air. The latter kind seems to have been largely overlooked, and efforts have been directed so far chiefly toward measures for preventing direct cross-infection through contact.

To control airborne infections it is necessary to prevent air from moving from one patient to another. Obviously this can be done effectively only if patients are separated from each other by means of airtight walls, that is to say, if each one is isolated in a single room. This is the ideal arrangement but it is expensive and has psychological objections, especially for older children. Apart from these objections, however, individual isolation for children to prevent cross-infection does not seem to have been given any consideration whatsoever, in spite of the fact that there are hospitals for adults in the U.S.A. with single rooms for each patient and also that the protection and comfort of a child, with his greater susceptibility to infection, ought to be of at least the same importance.

Meanwhile, careful studies in many quarters—latterly, for instance, in the "Cradle" in Evanston, Ill.—have shown that airborne cross-infections can be avoided if the infants are separated from one another in closed rooms or cubicles, which is a handier and more space saving arrangement. Then arises the question of the heating and ventilation of these cubicles, as obviously the doors of these rooms or cubicles cannot be made absolutely airtight; but air must be prevented from passing from one cubicle to another. This is possible only if the air, by some mechanical means, is forced into the cubicles and exhausted into the corridor outside. The air pressure must be kept somewhat higher in the cubicles than in the corridor, thus forcing it to flow from the cubicle through a vent in the wall or through a door into the corridor. At the same time, it is of the greatest importance that the walls between the cubicles are absolutely airtight.

An important medical requirement is that the temperature can be controlled, and the younger the child the more important this is. At the same time it is very desirable that the humidity also can be controlled, particularly in the cubicles for premature babies. It is not necessary to have separate humidity control in each cubicle. It suffices if humidity control is confined to one or two groups of three or four cubicles in each group.

The group, or groups, of cubicles would form part of a ward unit for say twenty to twenty-five babies, but it would be possible to vary the temperature and humidity of each group of cubicles independently of the main part of the ward and of each other. Generally speaking, a higher temperature and humidity would be required for the premature babies than for the normal ones in the main part of the ward unit.

The regulation of pressure, temperature and relative humidity of the conditioned air constitutes a delicate technical problem, particularly where economy in first cost and in operation must be considered, involving in many cases the employment of a single central station plant rather than a multiplicity of smaller plants. The air from this plant must be led to each separate cubicle. For the prematures there can be provided either a separate unit for each group or a secondary plant, reheating and rehumidifying the air from the main plant to a higher temperature and humidity.

The return of the used air, or a part of this air, to the air conditioning plant and using it over again in order to save heat is common practice where a high degree of sterility of the air is not required, but it presents fundamental difficulties when sterility is essential. Sterilization of the air may be effected by the use of ultra-violet light, but as this creates ozone to such a degree that it may have an intoxicating effect on the children and as no other really reliable way seems to ex-

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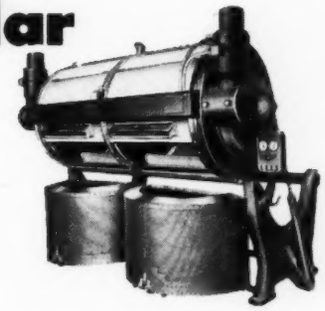

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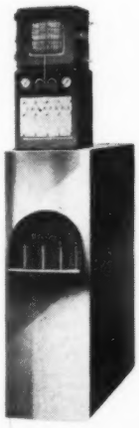

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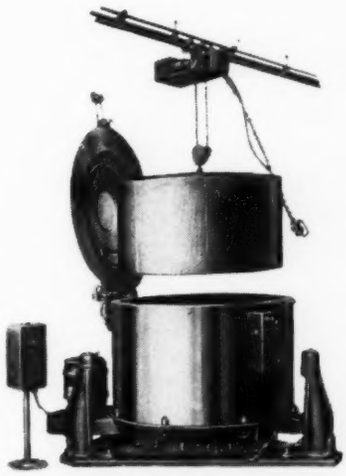

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ist, the used air must be exhausted directly into the open through ducts which must carry the exhaust air to the top of the building and must be separated from each other in such way as to prevent any possibility of contamination of one exhaust duct by another, should the plant by some mishap stop operating.

It will be appreciated that should the plant stop, there is always the possibility of air flowing back through the exhaust duct system with the hazard of contamination unless the precautions outlined are taken. Also, the supply air must be taken from a place that is remote from any contamination by the exhaust air. An airtight damper should be placed in the main supply duct which would close automatically in the event that the supply fan stopped. This will prevent the air from flowing backwards, which could involve risk of cross-infection.

There are various systems of air conditioning which are suitable for the conditioning of hospitals and it is difficult to determine the best one without careful study of the problems involved. However, in the case of the children's hospitals under consideration, in which it is proposed to incorporate a number of small rooms or cubicles, the most suitable system seems to be that of employing a central station air conditioning plant together with air distributing ducts.

The method generally used is to take in fresh air from a place where it is as clean as possible—in general, as high as possible above the ground; let it pass through a filter, and wash it. In the washing process, the air is at the same time humidified to 100 per cent and given the same temperature as the water. After this process the air is heated and led to the rooms to be conditioned. It is clear that there are two ways of controlling the temperature and humidity of the air: (1) during the washing process by regulating the temperature of the water, and (2) by the degree of heating to which the air is subjected after the washing process.

It is a known physical law that the amount of moisture air can contain in the form of water vapor is dependent on the temperature of the air. The higher the temperature, the higher the possible moisture content—and vice versa. When the temperature of the water in the humidifier is raised the temperature of the air passing through is also raised and the air will emerge saturated at this temperature — saturated because it is in intimate contact with a finely atomized spray of washing water.

If the air is subsequently raised to a temperature still higher by means of after-heaters, but out of contact with water, it will be able to contain more water than would be the case at the lower temperature, and its relative humidity will therefore fall. From this it will be appreciated that the temperature and humidity of conditioned air can be controlled to any degree of temperature and relative humidity desired. If it is desired to raise the relative humidity in a room, this can be done in two ways:

1. By raising the temperature of the water, in which case the room temperature would be kept constant.
2. By lowering the temperature of the room, in which case the temperature of the water spray would be kept constant.

VARYING THE DEWPOINT

In the event that it is desired to raise both temperature and relative humidity, then the temperature of the air must be raised to the required degree and at the same time the temperature of the water spray must also be raised sufficiently to ensure that the air contains sufficient water vapor to give the desired relative humidity at this new temperature. The saturated temperature of the air is known as the "dewpoint."

Any combination of temperature and relative humidity is possible by varying the "dewpoint" and "final temperature" of the air.

It should be mentioned here that there are other ways of varying the dewpoint than by varying the temperature of the spray water. This can also be done by mixing return air and fresh air from outside, thus controlling the temperature of the air entering the washer. However, since it is not recommended that any return air be used, this method of varying the dewpoint does not enter into this discussion.

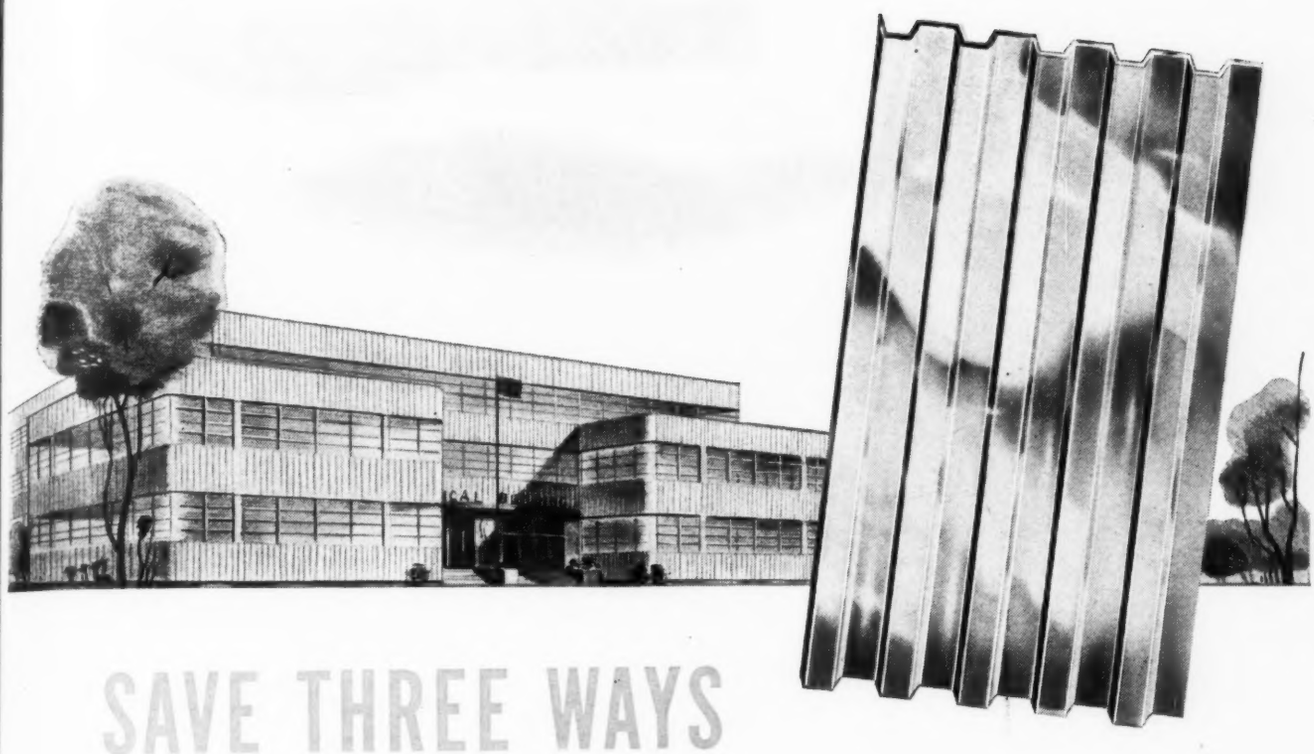
The employment of dewpoint control at the washer and temperature control by means of a single after-heater gives poor flexibility of control in the individual spaces or cubicles to be conditioned. Some supplementary form of heating must be provided in the spaces proper. It will be appreciated that, as the sun travels around a building, the part on which the sun's rays fall will require less heating than do those parts in the shade. This supplementary heating can be provided by radiators which are thermostatically controlled, and these radiators can be installed in each of the cubicles. In effect, the air supply will provide the necessary ventilating increment together with the proper control of humidity conditions in conjunction with the thermostatically controlled radiators. Fine control of individual space conditions cannot be obtained without some such arrangement. By ensuring that the temperature never rises too high in any of the rooms, a saving in heat, and therefore in fuel, results—an important matter from the standpoint of economy in operation.

In many places it is necessary to cool and dehumidify the air during the summer months. This changes nothing in the principles involved; it is merely a question of cooling the water in the washer instead of heating it. A refrigerator replaces the boiler; alternatively, if there is a sufficient quantity of well water at a low enough temperature, this can be used in place of a refrigerator.

Attempts have been made to control cross-infection by other means than by isolation. Floors, bedclothes and the clothes of the patients have been treated with special adherent substances in order to prevent dust from diffusing into the air. Germicidal vapors and ultra-violet rays have been tried. To a certain extent, these methods have given promising results, but they can probably never supplant individual isolation and at the moment can only be considered as a complementary form of protection against cross-infection.

If the costs of air conditioning can be kept within reasonable limits, then it is desirable that it be extended to other rooms and departments in a children's hospital. The fact to be remembered is that the older the child, the fewer are the risks attached to the commonest cross-infections.

Air conditioning has now come to be regarded as a necessity in hospitals throughout the world and is without question one of the most important ways to ensure the control of airborne diseases and the prevention of cross-infections. With careful attention from any ordinarily intelligent and conscientious plant attendant, it will function without trouble indefinitely. Occasional visits from a local service man will ensure that control instruments are kept in proper adjustment.



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HOUSEKEEPING

Conducted by Alta M. La Belle and Jane Barton

Hospitals Preferred

I have been asked why I prefer hospital to club or hotel housekeeping.

I lived for a time in that part of our country where hospitals and registered nurses were miles away. The country doctors, with the help of a kindly neighbor or relative, did splendid work, but so many more could have been helped and returned to a life of usefulness if a hospital had been available. It made me appreciate the advantages (both to the medical profession and to the patients) of such organized services which we in cities take for granted.

I have made a comparative study of housekeeping in the various fields and found that ownership in the hospital remains the same over a long period of time, thereby producing a continuity of control. The executive housekeeper is chosen, passed upon by the directors and retained for her ability regardless of any change in medical or business administration, whereas in the other related fields mentioned, a change of management usually means an entire switch in staff. She stands alone—no part of the medical or nursing departments—yet, indirectly, she contributes much to their success not only through her understanding of cleanliness and sanitation, but also through her knowledge of interior decorating and creating attractive and restful color arrangements throughout the hospital.

It is well known that colors do affect people (sick or well); some colors are very depressing and irritating while others are restful and soothing. It is surprising how just an uneven hem line in a window curtain can upset a patient, not only causing more work for the doctors and nurses, but delaying the patient's recovery.

What I am trying earnestly to say is that any executive, and particularly a woman executive, can give a great deal more, can put more of herself into her job, if she is given a certain autonomy along with a certain security of tenure. This gives her poise and serenity, makes for the personal touch in her daily routine and so brings to the hospitalized patient some of the needed home atmosphere.

It is a blessed cycle with rewards that are intangible as well as material.—CHARLOTTE PENN STEELE.

What's in a Name?—$10

Do you have a better name for "executive housekeeper"? That title has been annoying a lot of people for a long time, but no one has come up with a better one. Now, Mrs. Anne Stowell of the Stowell House in Los Angeles feels so strongly on the subject that at the biennial congress of the National Executive Housekeepers' Association, she offered a prize of $10 to the member who submits the best name as a substitute for "executive housekeeper."

All entries are to be in Mrs. Stowell's hands by December 10, and they will be judged by the national board of the N.E.H.A.

Where 150,000 Hustling Feet Prove There's No Match for WHIZ FLOOR WAX

World's Greatest Grain Market—The Chicago Board of Trade

On many a day the great skyscraper that houses Chicago's famed "grain pit" is used by 75,000 people—a challenge to the management's demand for flawless maintenance. Today, after years of testing, they use a number of Whiz products. Read the whole letter that tells you why. For instance, Whiz Heavy Duty and Super Floor Waxes mean "better-looking floors" . . . "finish lasts longer" . . . "cuts down labor cost" . . . "substantial saving of materials."

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BOARD OF TRADE
OF THE CITY OF CHICAGO

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August 30, 1948.

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Camden, New Jersey

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Our experience with your products in maintaining our building since early 1946 has been so satisfactory that we think it will interest you.

The heavy traffic in the grain pits and all through our building means a tough test on the floor finish. Your Heavy Duty and Super Floor Waxes, with Whiz-Off as a pre-wax cleaner, gives us better-looking floors than anything we ever used.

The fact that the finish lasts longer cuts down our labor cost, and in addition our records show a substantial saving of materials.

We are glad we can tell you that your other products are giving the same satisfaction as Whiz Floor Waxes.

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T. Coull
Superintendent of Building

TC: MA

The complete Whiz line includes:

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READER OPINION

(*Continued From Page* 10.)

lieve you will agree this is somewhat of a misrepresentation of content, because on comparison with the original data it is evident no attempt has been made to evaluate one factor as opposed to the other.

Of course, all of us fortunate enough to have taken the training value the prestige; I have yet to hear of a student belittling the content of the training, as is implied by your writer.

May I state that I am in sympathy with the basic objective of the editorial? It is well to scrutinize both the objectives and the content. Perhaps the writer of this particular editorial has additional evidence which leads him to believe that the points mentioned are constructive items of criticism. If an error has been made by him in reading more into this student survey than was intended or is evident on reexamination, I feel confident it was done only to drive home more clearly the basic idea behind the statement.

This particular survey to which we have reference was summarized before a large number of students and interested friends of the various programs in hospital administration at the Tri-State convention in Chicago in May. Practically the entire enrollment from the Chicago, Minnesota, Northwestern and Washington programs was present and heard the presentation. In fairness to those students whom the survey purported to represent, and in deference to the university programs in hospital administration which are attempting to emphasize both philosophy and technic of administration, I appreciate this opportunity of stating the student's point of view as surveyed by me earlier this year.

Roy C. House

Administrative Intern
Methodist Hospital
Indianapolis

The survey referred to in the opening paragraph of the editorial was the one made by Mr. House. However, this was not by any means the only evidence on which the editorial was based, or even the main evidence. In letting it appear as the only evidence referred to, we may have done an injustice to students. The phrase "as opposed to the actual content of the training" was included to clarify the meaning of "prestige or label value" and not with any intent to belittle course content.—ED.

NEWS DIGEST

Blue Cross to Go Ahead With National Plan . . . Hospital Industries Seek to Improve Conventions . . . Norby Asks Support for Public Education Program . . . Grace Bulman Receives A.D.A.'s Copher Award

Blue Cross Goes Ahead With National Plan; Doctors to Seek A.M.A. Advice

FRENCH LICK, IND.—Blue Cross plans moved another step toward realization of their ten-year dream for a national voluntary health service by voting yes on the proposed Blue Cross-Blue Shield insurance company at the annual conference of plans here last month. In concurrent session, members of Associated Medical Care Plans, Inc., referred the proposals to the house of delegates of the American Medical Association.

Blue Shield officers pointed out that no A.M.A. decision would be binding on the medical plans, but it was plain that the doctors intended to act as the house of delegates advised. As the meetings here closed, many observers were predicting that the national insurance company proposals would not be approved at the December session of the A.M.A. but would be held over for further study and discussion.

Anticipating this outcome, the Blue Cross group passed a resolution authorizing its commission to go forward with the national plans without Blue Shield, if necessary, but to leave the door wide open so the doctors could come along later if they wanted to.

The Blue Cross actions were taken by roll call vote; little opposition to the proposal was expressed, although a number of plans refrained from voting pending authorization by boards of trustees.

As discussed and approved by the house of delegates of the American Hospital Association at Atlantic City in September, the Blue Cross-Blue Shield Association would own and operate a stock insurance company, Blue Cross-Blue Shield Health Service, Inc., which would insure employes of national organizations in areas that are not covered by existing prepayment plans and equalize benefits among plans for such groups.

At the joint meeting of Blue Cross and Blue Shield representatives which opened the conference, Dr. Paul R. Hawley, chief executive officer of the two commissions, urged speedy action on the proposals as a necessary defense against compulsory insurance. Referring to the Ewing report on the nation's health as "the greatest challenge ever hurled at voluntary prepayment plans," Dr. Hawley said the report would convince many people with its argument that "voluntary plans can never do the job."

"Ewing is right today," Dr. Hawley concluded, "because voluntary plans are not properly organized to give better service. How long can we afford to let him be right?" he asked.

In another talk at the joint opening session, Harry Becker, welfare director of the C.I.O.'s United Automobile Workers union, laid down demands his union is going to make in next year's collective bargaining negotiations with the automobile industry. Hospitalization and medical care plans are high on the list of union demands, Mr. Becker stated, adding that labor would expect such plans to be wholly paid for by management, instead of by workers on a pay roll deduction basis. Mr. Becker also said the unions wanted service benefits instead of cash indemnities. "Blue Cross is the best buy for labor," he concluded, "not because of its ideology but on a dollars and cents basis."

Presenting his annual report to the conference, Richard M. Jones, Blue Cross commission director, said 31,210,819 members were enrolled in eighty-nine approved plans at the end of the second quarter. In the first half of 1948, he reported, $132,162,960 was paid to hospitals by plans.

Annual public relations awards went to Pat Murphy, Group Hospital Service, Texas; Ruth Brannan, Chicago Blue Cross; James A. Waggener, Indiana, and to public relations directors of the Nebraska and Oregon plans.

Norby Asks Hospitals to Support Program of Public Education

CHICAGO.—The truth about hospitals must be widely understood by the public as a necessary prelude to public support, Joseph G. Norby, president of the American Hospital Association, said last month in a memorandum asking member hospitals to contribute amounts equal to one-third of their annual association dues to the national public relations program to be projected with the assistance of the Advertising Council. The program was approved by the association's house of delegates at Atlantic City in September.

"Many people take hospitals for granted," Mr. Norby said. "They see the hospital building and have varying ideas as to its purposes and how it functions. Few fully understand individual responsibility for its continued successful operation and progress.

"Hospital problems and achievements must be directed to the attention of the entire public. The public does not necessarily have to do anything about them. But hospitals do need public support and must achieve public understanding before they will obtain support."

Hospitals were urged to pledge their contributions to the public relations campaign right away. "We cannot go forward with this program unless a sufficient number of hospitals agree to participate and support it," Mr. Norby concluded.

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NEWS...

Hospital Exhibitors Study Methods of Improving Convention Value

CHICAGO.—An extensive program to improve the educational value of exhibits at hospital association conventions is planned by the Hospital Industries Association as a result of a study of conventions conducted by Edgerton Hart, executive secretary, it was announced at association headquarters here last month. The survey covered one national, one state and three regional hospital meetings, it was explained.

Among the important objectives of the new program is the development of a formula to measure the value of conventions in such a way that hospital association officers and exhibitors can work together to improve the quality of attendance.

For example, "Simply to say that 7000 people registered at a convention means nothing," the survey report stated. "The true value to exhibitors lies not so much in the quantity as in the quality of the attendance. To go to an extreme, if 6900 of those in attendance were exhibitors themselves, flunkies around the hospital, and the general public, while there were only 100 department heads and administrators in authority to buy or approve hospital equipment, the convention would be of little value to the exhibitors.

"On the other hand, if a very high majority of the 7000 in attendance were people in authority at the hospitals, the meeting would have considerable value. Evaluating each convention with the same formula would soon give definite indications as to which conventions are decreasing in value, enabling H.I.A. to determine where it is necessary to work with hospital association personnel to analyze the reason for the situation and, in a spirit of helpfulness, assist the association to increase the value of the convention."

One method of evaluating convention attendance, the H.I.A. report suggested, would be the adoption of a distinctive, uniform system of badges for those attending all hospital conventions. Under this system, it was explained, "key personnel from the hospitals would be given registration badges of a color distinct from badges issued to exhibitors and relatively minor personnel."

The colored badge method, it was pointed out, would be a great help to exhibitors and their staffs. "It often happens that while four or five persons are standing around looking at an exhibit, the staff men in the exhibit are engaged in conversation by minor delegates, and key delegates are given no attention whatever, due to the impossibility of recognizing the important individuals in a group," the survey report explained.

The H.I.A. program will also urge registration by mail in advance of conventions wherever possible, especially for exhibitors, to avoid loss of time at jammed registration desks on the opening day. Other points in the program include:

1. Scheduling hospital conventions to avoid conflicts in dates.
2. A study of the costs to H.I.A. members of hospital convention exhibits.
3. Cooperation with hospital associations in the promotion of convention attendance.

For the first time this year, the H.I.A. will maintain a central office here under the full-time direction of Mr. Hart. Assisting him in the operation of the office and in effecting the new program will be a committee consisting of Thomas G. Murdough, H.I.A. president; E. Jack Barns, trustee, and George J. Hooper, secretary-treasurer.

Receives $500,000 Contribution for Campaign

WINCHESTER, VA.—The Winchester Memorial Hospital here has received a gift of $500,000 from Frank N. Hack, a member of the hospital executive committee for many years, Dr. Hunter H. McGuire, hospital president, announced last month. The gift will be placed in the hospital building fund to be used for expansion of hospital facilities and enlargement of the nurses' home, it was announced.

In making the donation the philanthropist stated his conviction that expanded modern hospital facilities should be provided to continue to make the community attractive to well trained physicians.

The hospital is currently carrying on an $850,000 campaign for funds to support a building program. Mr. Hack's gift, it was explained, is in addition to the $850,000 objective.

NEWS...

Grace Bulman Receives Copher Award at A.D.A. Meeting in Boston

BOSTON.—At the final dinner session which closed the American Dietetic Association's thirty-first annual meeting, the Marjorie Hulsizer Copher Memorial Award was presented to Grace Bulman "in recognition of her meritorious achievements as chief of the Dietetic Section, Medical Division, United States Veterans' Bureau, and later chief of the Dietetic Division, Department of Medicine and Surgery, Veterans Administration . . . during which she has established high standards within her sphere of responsibilities and brought nationwide advancement to the profession through her quiet yet dynamic leadership, her untiring effort and exceptional ability, her courage and deeply unselfish devotion to its noble purposes."

In conferring this, the association's highest honor, Dr. Helen Hunscher, president, said in part: "Through twenty-five years, the aftermath of two world wars, and three administrations of veterans' services, she has steadily and effectively pursued her high objectives—the nutritional betterment of hundreds of thousands of veterans within these hospitals." Miss Bulman directs the work of nearly 700 dietitian members of the American Dietetic Association and the food services in veterans' hospitals throughout the country.

While food, its highest nutritional use for mankind, its world supply and outlook, its cost, its preparation and service formed the focal point for discussions during the five-day sessions, better public relations held the spotlight throughout the week at Mechanics Building and the Hotel Statler, official headquarters.

Watson Davis, director of Science Service, Washington, D.C., pointed out that the intellectual fare of the public regarding medicine, science and technology is immensely better than it was a decade or so ago. Newspapers and other mass media are alert to the "proper nutrition of the human intelligence" in the fields of science as in other areas of interest. But professionals in the use of food should aid the newspaper writer, the radio commentator, the advertising writer, and the teacher in their task of informing the public.

If we are to raise the nutritional level, we must educate, we must persuade people, said Dr. Clair E. Turner of the National Foundation for Infantile Paralysis. But neither these nor economics are the sole factors in controlling the dietary. Six assured procedures were suggested: enrich common foods like flour and margarine where practicable; legislate to guarantee the nutritional and sanitary quality of food; improve the quality of commonly used products by better agriculture, more scientific manufacturing, and better food preparation; supplement the diet when direct food distribution takes place as in the school lunchroom; invent supplementary foods with taste appeal; use food education effectively—make it simple.

From another point of view, that of the psychiatrist, Dr. Henry M. Fox, Harvard Medical School, sounded a note of caution. The ingestion of food has emotional significance of far-reaching importance. The early patterns of infancy and childhood become firmly woven into the human personality and "continue to be powerfully operative

(*Continued on Page* 174.)

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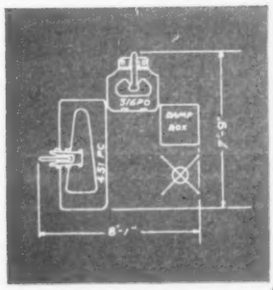

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NEWS...

N.Y. Mental Hygiene Department Starts In-Service Workshops for Nurses

ALBANY, N.Y.—A series of regional workshops for in-service training of graduate nurses was instituted last month by the New York State department of mental hygiene, according to an announcement by Dr. Frederick MacCurdy, commissioner. More than 100 nurses have registered for the opening sessions at Kings Park State Hospital and Rome State School, the former serving the hospitals of the Long Island area and the latter the central upper New York area, Dr. MacCurdy said.

The current series of workshops is designed to give 1200 graduate nurses in the department an opportunity to devote a period of intensive study to specific nursing problems, it was explained. The fall program emphasizes problems in the care of patients on the ward services in such areas as standard nursing procedures, methods of recruitment, management policies and procedures, ward teaching manuals, and forms and records. A spring series will be related to problems in the nurse education program of the state hospital schools of nursing. The program was initiated in the Long Island and the central upper New York regions; the mid-Hudson area and the western area opened workshops a few weeks later at Harlem Valley State Hospital and Craig Colony, respectively. The metropolitan program will begin November 28 at Creedmoor State Hospital, the announcement stated.

A series of four workshops is to be conducted in each of the five regional areas; each of the twenty workshops will be attended by a group of approximately sixty nurses. Thus, during the course of the year, the full complement of 1200 nurses will have an opportunity to attend. It is planned to set up workshops at a different institution each successive year, thereby rotating the workshop centers in each region.

In general, Dr. MacCurdy pointed out, these workshops are organized on an annual basis to make eventual provision for the training of all nursing personnel in new technics and therapies so that they can carry out their assigned duties in keeping with progressive standards. The nursing workshops, like the food service training school which opened earlier this month at Hudson River State Hospital, are part of the department's comprehensive program of in-service training provided for all levels of personnel with the specific objective of improving the state's service to its mental patients.

Department of Preventive Medicine Set Up

COLUMBUS, OHIO. — Establishment of a department of preventive medicine in Ohio State University's college of medicine was announced October 27 by Dean Charles A. Doan. The department will coordinate instruction of medical students in public health, nutrition and industrial hygiene, accenting health conservation as well as control of disease, it was explained. An important function of the new department will be to provide a link between the university's health resources and those of the community and state, and its staff also will participate in a program of research activities, the announcement said.

NEWS...

Hamilton Envisions Hospital of the Future at A.C.S. Conference

LOS ANGELES.—A hospital offering more privacy for patients, at lower costs than they have to pay today, was envisioned as the institution of the future by James A. Hamilton, director of the hospital administration course at the University of Minnesota, in a major address at the Hospital Standardization Conference of the American College of Surgeons here last month. Mr. Hamilton said the hospital of the future will be less centralized in operations than are today's institutions. "I hope each patient will have a private room and that his room will be the workshop for his treatment, instead of such treatment being too much centralized elsewhere in the hospital," he said.

Mr. Hamilton also foresaw shorter hospital stays for patients with acute disorders and greater attention on the part of the general hospital to patients with chronic diseases and other conditions now cared for largely in specialized institutions. He also predicted greater hospital emphasis on diagnostic services and industrial medicine.

Retiring as president of the college, Dr. Arthur W. Allen of Boston called for greater contributions by philanthropists and industry for hospitals and medical schools.

In one of the first public statements on the subject ever to come from a professional meeting, Dr. Malcolm T. MacEachern, associate director of the college, described the renewed efforts that are being made to stamp out fee-splitting and unnecessary operations. "There can be no compromise in our fight against these pernicious practices," Doctor MacEachern declared. "We cannot leave the burden of correction to outside agencies. It is still from within that the chief emphasis must come to maintain surgery as an honored profession."

Acknowledging that the practice is widespread in some communities, Doctor MacEachern said this is not any reason why the individual surgeon must not stand his ground and refuse to follow. He described the college standardization program for hospitals, aimed at eliminating these and attendant evils by raising surgical standards. "The goal of improvement in surgery is rapidly being attained since the end of the war," he concluded.

NEWS...

Roberts Elected President of Johns Hopkins Board

BALTIMORE.—W. Frank Roberts was elected president of the board of trustees of the Johns Hopkins Hospital at a meeting of the board held here last month, it was announced. Mr. Roberts is the sixth president of the Hopkins board. He succeeds the late W. Wallace Lanahan, who died August 30. An industrialist and civic leader, Mr. Roberts was first elected to the Hopkins board in 1928. Mr. Roberts is president and chairman of the board of the Standard Gas Equipment Corporation. He is a former president of the Baltimore Association of Commerce and is a member of the executive committee of the Baltimore Community Chest.

Mr. Roberts said his major concern as president would be the effort to maintain the level of community service rendered by the Hopkins Hospital in spite of the severity of the hospital's financial problems. "This hospital," he said, "wants to continue to render medical care to large numbers of the sick poor of Baltimore and Maryland. Unfortunately, its ability to do this does not match its desire to do so. At the present time, the hospital is dipping deeply into its capital funds to render this service to the sick poor. There seems to be a generally held impression that Hopkins is a wealthy institution. Nothing could be more incorrect. It is important that the community know that the hospital resources are limited and that they are far from equal to the burdens now being placed upon them by the medical care given to those who cannot afford to pay costs."

Educate Public to Needs of Hospitals—Jones

ELGIN, ILL.—What informed citizens can do to effect better public understanding of the voluntary hospital and its problems was outlined by Everett W. Jones, vice president of The Modern Hospital Publishing Company, Inc., at the fiftieth anniversary celebration of the Sherman Hospital here last month. Mr. Jones was the principal speaker at a public meeting attended by several hundred people on the evening of the anniversary celebration. Charles A. Lindquist, managing officer of the hospital, presided.

Mr. Jones outlined facts about hospital costs and operations which, he said, informed citizens should carry to the entire community. For example, he urged the group to "discuss with their friends the problem of indigent care and its effect on the hospital's ability to maintain high standards of service and pay its employes a fair wage."

Named Chairman of Memorial Women's Group

NEW YORK.—Mrs. Cornelius C. Felton took over the chairmanship of the women's society of Memorial Hospital Center here last month, the hospital announced. Mrs. Felton has served the institution in past years as a nurse's aide and as chairman of the women's division of the hospital's fund raising campaign.

In addition to its fund raising activities, which have brought more than $300,000 to the hospital in the last two years, the society trains hospital guides, holds lectures for members and others, provides services for child patients and cooperates in the recreational therapy program at the hospital.

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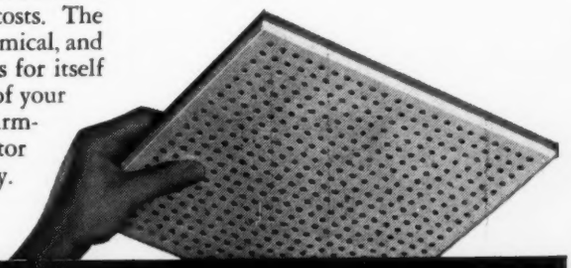

ARMSTRONG'S CUSHIONTONE

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NEWS...

England's Health Act Puts Government Between Patient and Physician

CHICAGO.—The United States has more well qualified physicians in proportion to its population than any other country in the world, Dr. Morris Fishbein, editor of the American Medical Association *Journal,* stated in an editorial in the A.M.A. magazine, *Hygeia.*

"Hospitals are widespread throughout the nation," Dr. Fishbein wrote. "Almost eighty medical schools act as medical centers where professors who are leaders in their fields teach medical students what is newest and best and make their services available to the people of the communities. As a part of the social revolution that has been going on in much of the rest of the world, various nations have established systems of medical care in which government plays a predominant part. The government usually collects a compulsory tax from every worker in order to provide medical care, either utilizing full-time salaried doctors or members of the medical profession willing to cooperate in the government plan, or paying all the costs of medical education and controling the distribution of physicians.

"I have just returned from a visit to England," Dr. Fishbein continued, "where the National Health Act became effective July 5, and also to France, Belgium, Holland, Denmark, Germany, Austria and Switzerland. Quite possibly, small nations of the type of Holland and Denmark and Switzerland, with a few million people concentrated in a small area and with all the people of a homogeneous type, can work out plans for organized medical service that would not be suitable to a nation like the United States.

"England has established a National Health Act under which everyone is taxed to support the health system. The British government is now trying to activate service so that the doctors may decide whom they will serve, so that people may go to hospitals and get eye glasses and false teeth and anything else that they need without additional payments beyond their taxation.

"From my visit to England I became convinced that the British gulped far more than they can handle. They are actually short of doctors, of competent specialists, of nurses, of technicians, of health centers, of medical facilities, so that even if they had the money to make the service effective they could not do it. Introduced into medical practice is now a new relationship whereby the government is a third party between the doctor and his patient."

Transparent Surgical Dressing Developed

NEW YORK—Doctors in an industrial medical research unit at Birmingham Accidents Hospital, Birmingham, England, have developed a transparent nylon surgical dressing which can be applied to wounds and need not be removed until healing is completed, according to a newspaper report here.

Dr. J. R. Squire, who reported the research project, was quoted as saying: "the dressing keeps bacteria, dirt and moisture out but allows perspiration to escape, so that the skin, though covered, remains healthy and dry. As you can see through the dressing without taking it off, the risk of infection is reduced."

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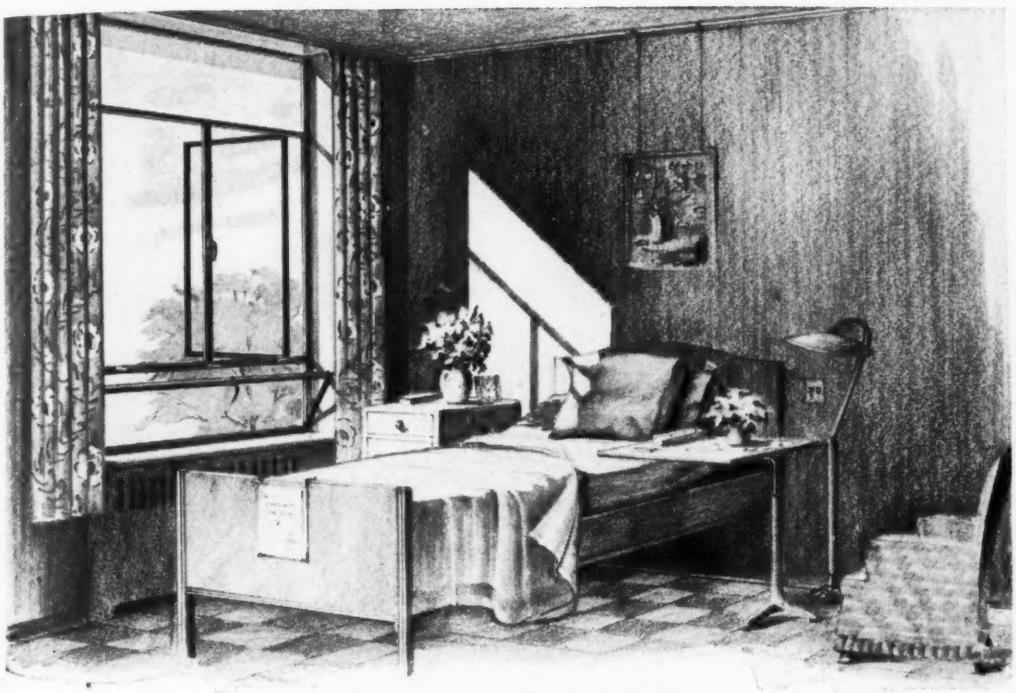

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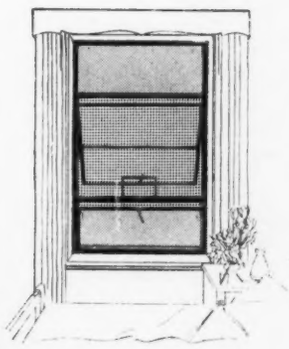

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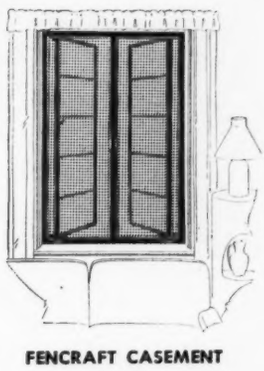

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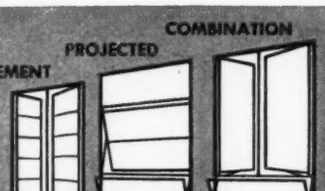

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NEWS . . .

Rusk Calls for Greater Emphasis on Rehabilitation of Sick and Injured

NEW YORK.—Although millions of dollars are spent on the prevention of accident and disease and many more millions on their treatment, the United States until now has neglected the third phase of medicine, the rehabilitation of the sick or injured person and his restoration to a useful and happy life, Dr. Howard A. Rusk of New York City told an association of life insurance medical directors here last month. Dr. Rusk is chairman of the department of rehabilitation and physical medicine at Bellevue Hospital, where a pilot program in rehabilitation is now being developed.

The Bellevue organization now has eighty hospital beds and when new construction is completed will have 600, offering a complete program of physical medicine and rehabilitation, including retraining, psychological adjustment and vocational evaluation and guidance for physically handicapped persons, Dr. Rusk reported.

The many factors that go into the rehabilitation and restoration of chronically ill persons, Dr. Rusk told his audience of 300 life insurance doctors, include physical therapy, occupational therapy, physical rehabilitation, social service, vocational guidance and testing and recreation. All of these are designed to teach the patient with a physical disability "to live within the limits of his disability but to the hilt of his capabilities."

In rehabilitation as in definitive medical care, the general practitioner is an essential and integral member of the therapeutic team, Dr. Rusk declared. Today, he said, as new and mounting demands are made upon the general practitioner to restore his patients to maximum economic and social effectiveness, he must turn to the expanding field of rehabilitation and physical medicine for increased technical skills and assistance, although many simple technics can be applied directly in the physician's office, home and hospital practice.

Change Hospital's Name

PENSACOLA, FLA.—The name of the Pensacola Hospital here has been changed to the Sacred Heart Hospital of Pensacola, it was reported recently in the *News Bulletin* of the Florida Hospital Association.

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NEWS...

East Orange Hospital and Upsala College Establish Program in Field Courses

EAST ORANGE, N.J.—Development of a coordinated program between East Orange General Hospital and Upsala College by which students in the various departments of the college can have the benefit of practical field courses in the technical departments of the hospital was endorsed last month by Edgar C. Hayhow, director of the hospital, and Dr. Evald B. Lawson, college president.

"There is every reason why the two East Orange institutions should join forces in their common endeavor of training young people," asserted Mr. Hayhow in outlining the workshop facilities of the hospital. "Training in the clinical observation of patients, outpatient service, large-scale dietetics, and statistical surveys are some of the opportunities provided at the hospital for Upsala students."

Affiliation of the hospital's school of nursing with Upsala was announced earlier this year. The college provides a scientific background in the physical and social science courses through a special eighteen-week course attended during the nurse trainee's first year. Participation of the nurses in the extracurricular program of the college is also being studied.

Upsala also maintains an affiliation with the Lutheran Memorial Hospital of Newark and offers a prenursing course leading to the bachelor of science degree.

Broadcast From Hospital Maternity Unit

NEW YORK.—Interesting sidelights on the maternity section of a voluntary hospital were presented in the radio program, "Minute Quiz," transcribed at the Woman's Hospital, New York City, and broadcast last month over the Mutual Broadcasting System. During a spontaneous fifteen-minute session, varying views on "how it feels to wait for the baby" were expressed by a father expecting his first child, a father visiting his wife and newborn son, and two nurses of long experience in maternity cases—mothers themselves. The program reached a climax with the entry of a nurse who announced to the expectant father, "It's a girl." Arrangements for the program were made by Associated Hospital Service, New York's Blue Cross plan.

NEWS...

Specialists and Hospitals Review Problems at Pathologists' Meeting

CHICAGO.—The second annual meeting of the College of American Pathologists here last month featured a round table discussion between hospital and specialty representatives on the relationships between the two groups in connection with the practice of pathology, radiology, anesthesiology and physical medicine.

The hospital view of the subject was presented by Graham L. Davis of Michigan, past president of the American Hospital Association, and Everett W. Jones, vice president of The Modern Hospital Publishing Company, Inc. The panel of physicians included Dr. W. E. Chamberlain, member of the American College of Radiologists board of chancellors; Dr. Ivan B. Taylor, a director of the American Society of Anesthesiologists; Dr. John R. Schenken, Omaha, Neb., pathologist, and Dr. Frank H. Krusen, representing the American Congress of Physical Medicine.

The discussion covered all aspects of the relationship of these specialists to the hospital administrator and board of governors and to other members of the medical staff. Emphasis was given to the economic problems involved in the relationships. On a show of hands requested by Mr. Jones, who served as chairman of the discussion, only a negligible number in the audience of more than 100 supported the view that "specialties have more to fear from hospitals and hospital administrators than from the government." Participants reported that a friendly spirit prevailed throughout the discussion.

In another round table program on the subject of "Fixed Salary *vs.* Fee for Service Basis in Medical Practice," E. G. Funke, deputy attorney general of the state of California, stated that under the law in his state and many others, unlicensed persons cannot practice medicine and corporations cannot be licensed. The legal problem thus becomes one of determining how far a corporation can go before it is engaged in the practice of medicine, Mr. Funke said.

The philosophy of the law on this point is that the public must be protected against healing methods used by persons without the proper background of knowledge and training, Mr. Funke explained. Whether or not hospitals are in competition with private practitioners in the specialties is beside the point as far as the state and the law are concerned, he added.

Repays Kindness Proferred at Johns Hopkins Hospital

BALTIMORE.—Clarence H. Miller was a 16-year-old farm boy from Churchville, Va., when he came to Johns Hopkins Hospital in 1899 because the right hip broken three years before by a horse's kick hadn't mended properly. After ninty-one days in the hospital and an operation by the late Dr. Joseph Bloodgood, the young farmer went home. He didn't forget what was done for him, and he didn't forget that he had no money then and wasn't able to pay for the operation.

Shortly after Mr. Miller died last month, the hospital received a $500 check from his widow, fulfilling his long-standing request that, at his death, a check be sent to the hospital to be placed at the disposal of some person or persons who like himself are unable to pay for an operation.

TWO WAYS

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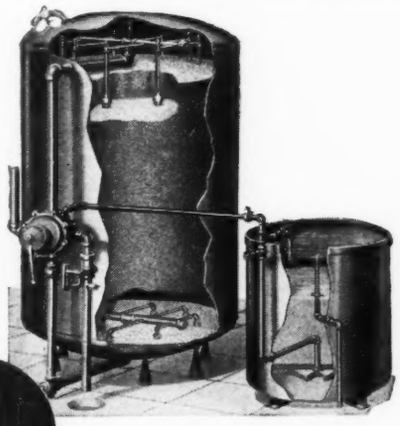
In thousands of installations the Elgin "Double-Check" principle has proved the most revolutionary development in Zeolite water softeners in recent years. The operating records of these installations show that the "Double-Check" softener delivers up to 44% more soft water, size for size, than any other—costs less to buy and operate.

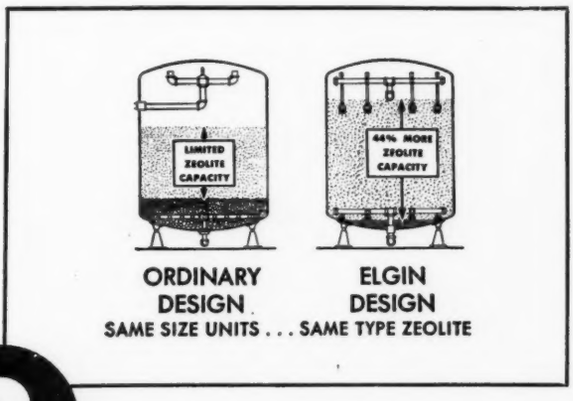
Note that there are two ways you can cut water softener costs with the "Double-Check" principle as pointed out here:—



1 ***By installing a new Elgin "Double-Check" Softener***

The accompanying diagrams show why the Elgin "Double-Check" Softener gives up to 44% more soft water per regeneration than others. Note that a softener of conventional design is compelled to use far less zeolite than an Elgin of equal size because it has no means of preventing the escape of zeolite during backwashing.

In the Elgin Softener, the "Double-Check" manifold arrangement prevents loss of zeolite even at a far higher backwash rate. The deeper zeolite bed that can be carried, means more water softening capacity, and the higher backwash rate means better opening up of the bed, more thorough regeneration by the brine, *more efficient utilization of more zeolite!* (This means that a smaller Elgin does the work of other larger softeners.)



2 ***By having the "Double-Check" Method applied to your present softener***

The dollar-saving advantages and extra capacity of the Elgin "Double-Check" manifold system can be fully realized by having it applied to any existing water softener. Indeed there could be no better proof of the merit of the "Double-Check" principle than the fact that operating men have had it applied to hundreds of softeners of every make.

Our district engineer will be glad to show you how your present softener of any make can be modernized (without having to buy a new unit) by installing upper and lower "Double-Check" manifolds as illustrated here with Elgin high capacity zeolites to suit your conditions. The net result will be a remarkable increase in soft water at far lower cost per gallon. (With the newer Elgin high capacity zeolites, you can get 3 to 10 times as much soft water per regeneration.)

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NEWS...

Opens Unit for Care and Study of Alcoholics

CHIPPEWA FALLS, WIS.—A state directed unit for the treatment of alcoholism as a disease was opened here November 1, it was announced by Walter O. Cromwell, director of the State Bureau of Alocohol Studies. Responsibility for operation will be borne jointly by the state and Chippewa County, it was explained.

The director of the new project is Roy Wheeler of Chippewa Falls and the assistant director is Mrs. Elizabeth Edler. The project will be in a unit of its own at St. Joseph's Hospital here, where the alcoholic patient will receive treatment aimed at complete and permanent rehabilitation.

"Establishment of the Chippewa Falls facility for the treatment of alcoholism is the result of the cooperation of a number of agencies and individuals," Austin Ripley of Colfax, Wis., one of the organizers of the facility, stated.

"Its establishment in Chippewa Falls was made possible by a grant by the state to Chippewa County, to which the county board added funds of its own. In a larger aspect, however, this facility was created through the deep understanding of the problem and the close cooperation of the county board, Sister Noel, superintendent of St. Joseph's Hospital, Alcoholics Anonymous, the American Red Cross, county welfare and other allied organizations.

"The facility at St. Joseph's Hospital is a new approach to this problem. Many general hospitals will not accept alcoholics as patients. Within its limitations, St. Joseph's facility will provide for its alcoholic patients the best of science and the art of healing," Mr. Ripley concluded.

"In the near future, adjoining counties will be invited to contribute so that the service will be enlarged and extended to the alcoholics of their communities, and the alcoholic will be recognized and treated for what he is, a sick human being suffering from an enormously complex disease."

A.P.H.A. Meets in Boston

BOSTON.—A number of subjects of interest to hospitals were scheduled for discussion here during the annual meeting of the American Public Health Association November 8 to 12. In addition to discussions of the Federal Hospital Survey and Construction Program by Public Health Service officials and hospital administrators, the association's medical care sessions were to include talks on regionalization of hospitals, group medical practice, principles of administration and personnel training.

Other talks of interest to hospitals were "The Effect of Rising Hospital Costs on Prepayment Plans" by C. Rufus Rorem; "Nursing in a Nationwide Program for Medical Care" by Ruth G. Taylor, and the "Montefiore Home Care Program" by Dr. Martin Cherkasky.

Plan Seven-Story Wing

BURLINGTON, VT.—Plans are under way for the opening of a new wing of the Bishop DeGoesbriand Hospital here, which will accommodate about 3000 more patients a year. The new wing has seven floors and a basement, including private and semiprivate rooms and wards, with a total of 100 beds. There are also facilities for outpatients and emergency cases.

NEWS...

Admit Howard U. Doctors to Gallinger Staff

WASHINGTON, D.C.—An agreement providing for the admission of physicians, interns and students from Howard University, Negro institution here, to the Gallinger Hospital was completed last month among the university, the District of Columbia Commission, which operates the hospital, and Georgetown and George Washington universities. The agreement, which was made informally last spring and completed with the signing of a formal contract last month, puts the Howard University staff on an equal basis with the staffs of Georgetown University and George Washington University, it was explained.

Under the contract, each of the three affiliated medical schools will furnish 25 per cent of the hospital interns as well as an appropriate proportion of attending physicians on the hospital staff. The remaining 25 per cent of the interns will be appointed by the health department and by district commissioners, Dr. George C. Ruhland, district health officer, said.

COMING MEETINGS

FLORIDA HOSPITAL ASSOCIATION, Wyoming Hotel, Orlando, Nov. 19-20.

MISSOURI HOSPITAL ASSOCIATION, Jefferson Hotel, St. Louis, Dec. 6-7.

NEBRASKA HOSPITAL ASSOCIATION, Cornhusker Hotel, Lincoln, Nov. 17, 18.

1949

AMERICAN HOSPITAL ASSOCIATION, Mid-Year Conference of Presidents and Secretaries, Drake Hotel, Chicago, Feb. 4-5.

ARIZONA HOSPITAL ASSOCIATION, Phoenix, Feb. 11-12.

ASSOCIATION OF WESTERN HOSPITALS, Civic Auditorium, San Francisco, May 9-12.

CAROLINAS-VIRGINIAS HOSPITAL ASSOCIATION, Asheville, N.C., April 21-22.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N. J., May 18-20.

MID-WEST HOSPITAL ASSOCIATION, Kansas City, April 26-28.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, Mass., Mar. 28-30.

OHIO HOSPITAL ASSOCIATION, Neil House, Columbus, Ohio, March 23-26.

SOUTHEASTERN HOSPITAL CONFERENCE, Buena Vista Hotel, Biloxi, Miss., April 27-29.

TEXAS HOSPITAL ASSOCIATION, Buccaneer Hotel, Galveston, April 19-21.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 2-4.

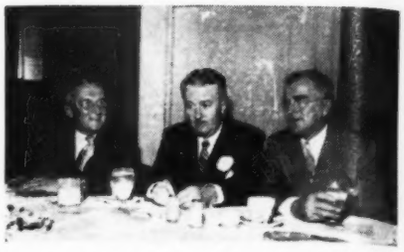
UPPER MIDWEST HOSPITAL CONFERENCE, Minneapolis, May 26-28.

NEWS...

Wesley Memorial Hospital Celebrates Sixtieth Year

CHICAGO.—The voluntary hospital must find the means of increasing the amount of aid it gives people who are unable to afford private hospital service, or these people will be forced to seek government aid, Jay L. Hench, president of Wesley Memorial Hospital's board of trustees, said at the hospital's sixtieth anniversary dinner here last month. Speaking to 600 civic leaders and friends of the hospital, Mr. Hench cited a recent report made by the Council of Social Agencies of Chicago indicating the rising number of visits made by Chicago's sick poor to the city's leading clinics. The present average number of clinic visits is running close to 155,000 per month—the greatest volume in the postwar period.

"This places an extra responsibility on the voluntary hospital," Mr. Hench said. "Yet, with a reduced return on endowments and with rising costs, it is in the position of either having to develop sustained income other than from its paying patients or reducing the amount of hospital service it renders the needy."



Jay L. Hench, Dr. J. Roscoe Miller and Dr. Herman N. Bundesen at Wesley dinner.

Mr. Hench stated that the cost per patient day at Wesley is two and a half times what it was five years ago, but that endowment return had decreased by 15 per cent in that period. He added that Wesley had made increases in its rates, but not in proportion to the increase in cost of providing care.

Mr. Hench called on voluntary hospitals to keep the general public informed throughout the year of their problems of operation, not just of the need for a new building at the time of a fund raising campaign. "Communities will support their hospitals, but they must know *why* it is necessary and what are the consequences if they don't. The hospital needs the community and the community needs the hospital," he concluded.

Others participating in the anniversary program were Mayor Martin H. Kennelly of Chicago, Dr. J. Roscoe Miller, president-elect of Northwestern University, and Dr. Vincent J. O'Conor, chief of the hospital's medical staff.

500 Attend Annual Maryland-D.C. Meeting

WASHINGTON, D.C.—Approximately 500 hospital administrators, department heads and other hospital workers from Maryland, Delaware and the District of Columbia attended the eighth annual conference of the Maryland-District of Columbia Hospital Association here November 8 and 9. Speakers included Joseph G. Norby of Milwaukee, president of the American Hospital Association, who addressed the group at a luncheon on the first day of the conference; Rev. Edmond A. Walsh, S.J., vice president of Georgetown University, Washington, D.C., who spoke at a dinner, and William G. Torpey, personnel consultant for the Navy Department in Washington, the principal speaker at another luncheon.

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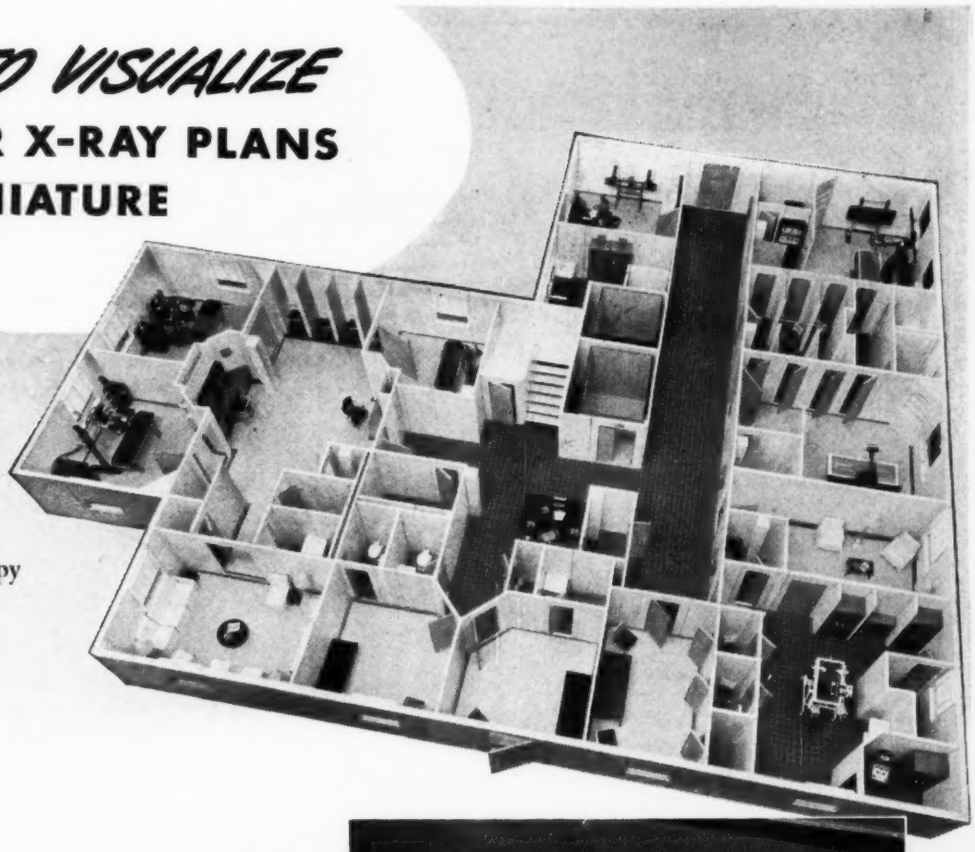

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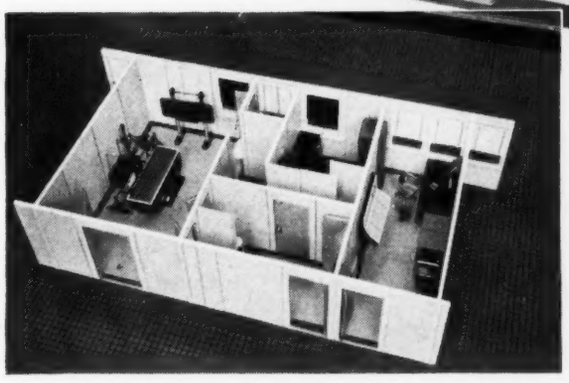
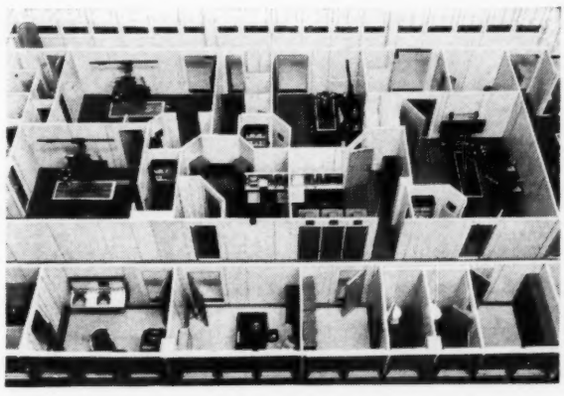


Radiographic Suite for a 50 or 100-Bed General Hospital



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NEWS...

More Young Men Needed in Field of Radiology

CHICAGO.—Radiology needs the superior, worthwhile men in medicine who have the vision to see the great future that lies ahead in that specialty and its allied sciences, according to Dr. Lawrence Reynolds of Detroit, newly elected president of the American Roentgen Ray Society. Dr. Reynolds is chief of the department of radiology at Harper Hospital, Detroit.

In an article in the current issue of the *American Journal of Roentgenology and Radium Therapy,* Dr. Reynolds says, "The whole history of radiology from its incipiency to the present time is one of steady development. Perhaps no single episode which has resulted from a scientific endeavor has so greatly influenced the progress of the human race as the discovery of the roentgen ray and radium, and there is no branch of medicine which has not benefited by their employment.

"The products of atomic fission are being used to discover how the human body converts food into fat, flesh, and energy," the article continues, "and how it repairs injuries and how radioactive isotopes seek out specific tissues and flood them with rays which in some cases have extraordinary healing power. Biologists are using them in other scientific efforts to catch the green leaf in the very act of making starch, sugar and cellulose with the aid of the sun. By the use of the products of atomic fission great progress is being made in illuminating some of the darker regions of physiology and chemistry.

"Radioisotopes today in their relation to general medicine are very much in the same position as radiology was fifty years ago. It began as a tool of the physicist and by gradual expansion in its medical application it became a department within itself. Since the government has made available in unlimited quantities radioisotopes for both research and treatment, there is opened up a wide field of investigation."

Eight Nurses Injured

MISHAWAKA, IND. — Eight nurses were injured in a fire at St. Joseph's Hospital's nurses' home here last month, the Associated Press reported. Most of the injuries were sustained when nurses who were trapped on the second floor jumped onto mattresses thrown to the ground, the report said.

NEWS...

Northwestern Hospital Approves New Contract for Graduate Nurses

MINNEAPOLIS. — The Northwestern Hospital here has approved a new contract covering salaries and working conditions for members of the professional nursing staff, Russell C. Nye, administrator, announced November 1. The contract provides for a forty-hour week for the graduate nurse staff, compared to the forty-four-hour week that has prevailed in the past.

Indicating that the forty-hour week will step up pay roll expense somewhat, Mr. Nye pointed out that the hospital has been preparing for this move by analyzing nursing operations with a view to conserving professional nursing time particularly by shifting many tasks formerly handled by graduate nurses to practical nurses and nurse's aides.

Mrs. Gertrude S. Thompson, president of the hospital board, said, "We feel we have a fine group of nurses and we want to encourage them to give their best service to our patients. It is the board's view that the shorter work week should result in even better nursing service. This is in keeping with the established procedure of the hospital to stay well abreast of the most progressive practices in the field of hospital care."

Under the contract, the base salary for general duty staff nurses is $185 a month. Assistant head nurses have a base of $190 and head nurses, $195, the hospital said. Six other hospitals in the St. Paul - Minneapolis area followed Northwestern in adopting the new contract, it was stated.

Cost of Surgeon's Training Estimated at $30,000

RUTHERFORD, N.J.—Preparing for a career as a surgeon is high on the list of the costliest professional undertakings in the United States today, according to an article appearing in *Medical Economics*. Dr. Henry A. Davidson, author of the article, reveals that the average independent surgeon's higher education costs his family in excess of $30,000. This includes four years of college, four years of medical school, one year as an intern, and four years of graduate surgical training.

In 1947 independent surgeons spent 30 per cent more for instruments and equipment than they spent for this purpose in 1943. The average surgeon's total investment in equipment is $4975, a *Medical Economics* survey revealed.

Commenting on the heavy initial expenditure before a surgeon actually engages in practice, Dr. Davidson's article states:

"For thirty-odd years the prospective surgeon is an expensive, nonearning unit. His productive years are reduced at one end by a long and costly training period and at the other end by the possibility of coronary occlusion. And some people wonder why a surgeon has to charge high fees!"

According to the *Medical Economics* survey, the average surgeon in 1947 saw twenty-one patients a day and worked an average of more than nine hours a day. The actual figure in any given case depends on the surgeon's location and age and the extent of free service given. Charity work done by surgeons varies considerably in volume; last year the average surgeon devoted more than eight hours a week to charity cases, the survey indicated.

Roller skates may not be the answer, but there *is* a practical way to save many personnel hours . . . valuable hours that can be spent on other duties. You know how much time is consumed with the preassembly of ordinary venoclysis equipment, with the bothersome cleaning and resterilizing afterwards. All this can be eliminated—as well as the risk of pyrogen reactions—by using Abbott's completely disposable venoclysis unit, VENOPAK, with Abbott Intravenous Solutions. • As soon as you open the convenient little package, VENOPAK is ready for action. It has passed exacting tests for sterility and freedom from pyrogens. It is quick and easy to assemble, adaptable to a variety of hookups. Use it once, then *throw it away*. The all-in-one unit consists of a dispensing cap, air filter, Murphy drip, plastic tubing, pinch clamp and needle adapter—with removable protective coverings on the dispensing cap and needle adapter. • The safety, the economy, the saving in personnel and processing time effected with the disposable VENOPAK and Abbott's ampoule-quality solutions can be explained in detail, and with specific examples, by your Abbott representative. Ask him for a demonstration—or write to Hospital Division, ABBOTT LABORATORIES, NORTH CHICAGO, ILLINOIS.

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New Color Film . . . A motion picture on "Modern Trends in Intravenous Therapy" is available to hospital groups. It illustrates techniques for intravenous therapy, blood banking and blood transfusions. Write to Hospital Division, Abbott Laboratories.

*Abbott's Completely Disposable Venoclysis Unit

NEWS...

United Mine Workers Set Up Hospital and Medical Service Plan

CINCINNATI.—A plan aimed at providing full medical and hospital service to 400,000 soft coal miners and their families was announced here last month by the United Mine Workers of America. The program is to be financed out of the $100,000,000 a year income negotiated by the U.M.W. last year for its welfare and retirement fund. Josephine Roche, welfare director, and Dr. Warren F. Draper, executive medical officer, said the plan will utilize private physicians and local hospitals to the maximum extent in providing full service without cost to the union's members and their families.

It is estimated that approximately 1,500,000 men, women and children in twenty-six coal-producing states will be covered when the plan becomes fully operative, the announcement said. In the beginning, however, benefits will be confined to families of deceased miners, those needing more specialized services than are available in local communities, and aged or ill members, it was explained.

Miss Roche and Dr. Draper emphasized the union's determination to use existing medical facilities and services wherever possible. "We are going to use what there is where it exists," Dr. Draper declared. "For the future we will do what is necessary to provide what is adequate for our people." The fund has no plans at present for a hospital construction program, Dr. Draper stated, although this possibility was not ruled out as an eventual undertaking.

Microbiological Institute Established at N.I.H.

WASHINGTON, D.C.—Realignment of the medical research program at the National Institutes of Health at Bethesda, Md., was completed last week with establishment of a Microbiological Institute, it was announced last month by Dr. R. E. Dyer of the U.S. Public Health Service, director of the National Institutes of Health.

"Within the last year two new special institutes created by the Congress—the National Heart Institute and the National Institute of Dental Research—have been established and the work of the National Cancer Institute has been enlarged," Dr. Dyer explained.

"The concentration of cancer, heart and dental research in these special institutes has made it necessary to regroup within the Microbiological Institute and the Experimental Biology and Medicine Institute, which was established last December, important research dealing with such diseases as malaria, polio, typhus and the common cold, and a number of basic research studies in such fields as physics, chemistry, nutrition, metabolism and pathology. This enables work in these diseases and fundamental research to go forward with the same intensified effort being given to cancer, heart and dental problems," Dr. Dyer stated.

Surgeon General Leonard A. Scheele has appointed Dr. Victor H. Haas director of the Microbiological Institute. Dr. Haas has been chief of a unit engaged in malaria research for the National Institutes of Health in cooperation with the University of Tennessee Medical School in Memphis, Tenn.

The new institute will concentrate on the study of infectious diseases, including virus, bacterial and tropical diseases.

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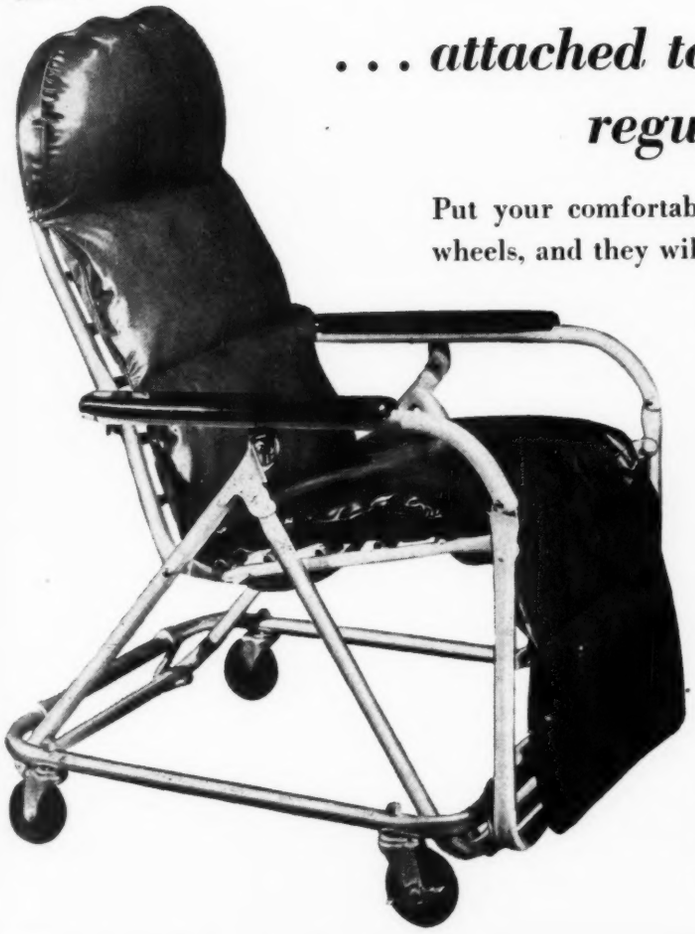

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The BarcaLoafer Dolly is sturdily made of tubular steel. Weight 15 lbs. Easy to attach or remove. Rear wheels are swivel; front wheels have a brake attachment.

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NEWS...

Planning and Construction, Public Relations Institutes Announced by A.H.A.

CHICAGO.—Planning and construction of hospitals to meet the community's needs and hospital-public relationships will be the subjects of two American Hospital Association institutes scheduled for December, it was announced here.

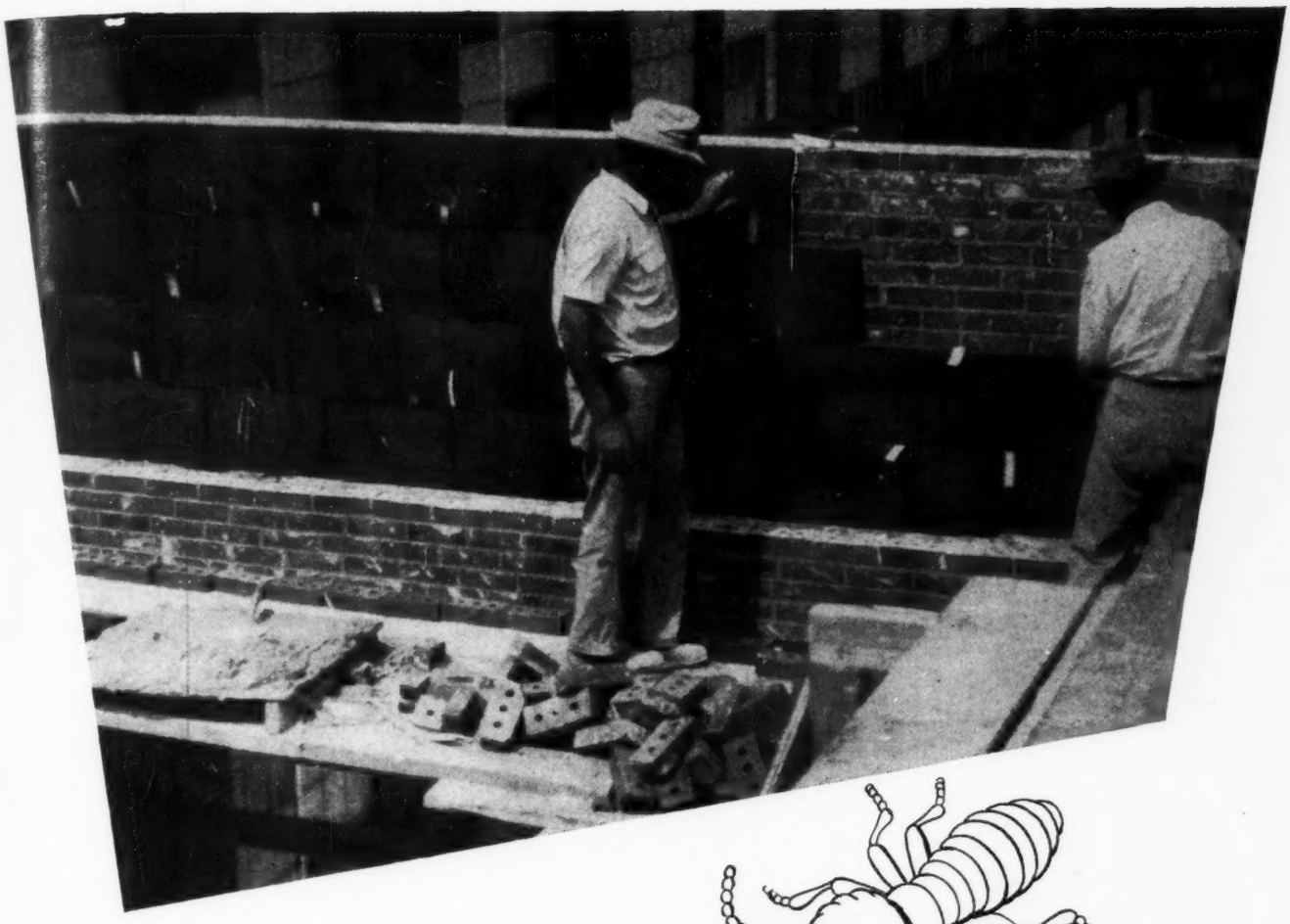
To aid hospital officials in working effectively with architects and construction specialists, an institute on hospital planning to be held in Washington, D.C., December 6 to 10, will trace hospital planning step by step. Beginning with discussion of surveys of hospital needs, the sessions will cover effective designing of service and patient areas, costs and maintenance, selection of materials and equipment, and ways to assure that the community can finance and support proposed hospital facilities. Special features will be a study of actual hospital plans and trips to well designed hospitals in the area.

Covering the principal areas of importance in a hospital's public relations program, an institute on hospital public relations in New Orleans December 6 to 8 will furnish a concentrated introduction to the subject for hospital administrators and public relations personnel. Outstanding speakers from hospital and allied fields will discuss public opinion surveys, relationships with groups in the hospital and the community, and effective ways in which the hospital may communicate with them.

Economy of Giving

CHICAGO.—The American Hospital Association has made available for distribution to hospitals a pamphlet entitled "Your Gift to Hospitals Through Taxes," explaining to prospective donors how their gifts to hospitals can be made most economically under present income tax requirements.

For example, the illustrated booklet points out that an individual with an income of $10,000 a year can save $450 in taxes on a hospital contribution of $1500. Other income tax saving features of philanthropic donations are set forth in text and tabulation. An important section of the booklet deals with the tax status of all corporations making philanthropic donations. An additional section has to do with gifts of securities.



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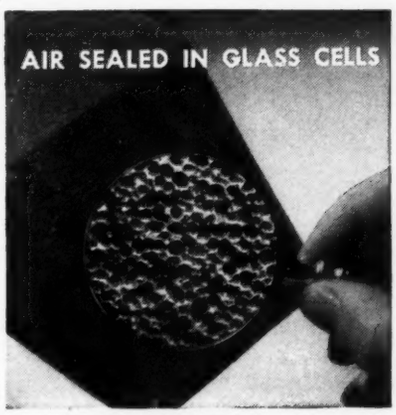

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NEWS...

Plan Consolidation of Two New York Eye, Ear and Throat Hospitals

NEW YORK.—A plan for consolidation of the Manhattan Eye, Ear and Throat Hospital and the New York Eye and Ear Infirmary was announced this month by the presidents of the two hospital boards. The new hospital will be known as the New York-Manhattan Eye and Ear Hospital and will carry on its activities at the location of the present Manhattan Eye, Ear and Throat Hospital, the announcement said.

Emphasizing the need for developing hospital facilities in line with general recommendations of the Hospital Council of Greater New York, the statement said that the merger plan would make possible better utilization of available facilities and coordination of training and research programs in the fields of ophthalmology and otolaryngology.

Plans for the move have been under way since September of this year, it was explained. "The merger is believed to be the best possible solution to preserve for the Greater New York area the volume and quality of hospital and clinic services for the care and treatment of diseases and impairments of the eye, ear, nose and throat for which the two hospitals have been noted for so many generations," the presidents' statement said.

It was pointed out also that the move will enable economies to be effected in the operation of the consolidated institution and will markedly reduce the personnel shortage, particularly in nursing. Current arrangements with New York University College of Medicine for instruction in the basic sciences of ophthalmology and otolaryngology will be continued and strengthened, it was added. It is contemplated that the directing boards and professional staffs of the two institutions will be combined.

Fund Drive to Raise $500,000 for Modernization and Building Program

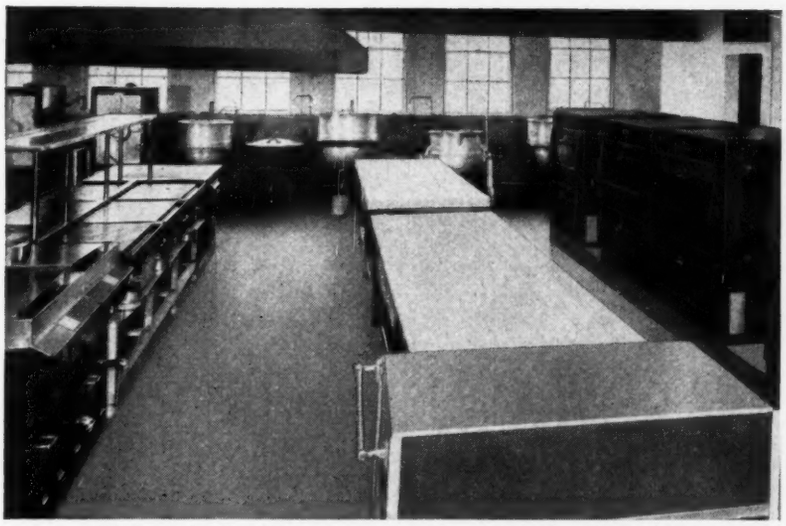
GRAND FORKS, N.D.—A campaign to raise $500,000 for necessary expansion of the Deaconess Hospital here was launched at a public dinner last month with Everett W. Jones, vice president of The Modern Hospital Publishing Company, Inc., as the principal speaker. It is expected that the drive for funds will be carried on throughout the month of November to provide the amount needed to construct a six-story addition and to modernize the present hospital building. The contemplated expansion program would provide the community with an institution of 220 beds as opposed to the present 145 bed hospital, which was termed inadequate in a recent survey.

In his address, Mr. Jones outlined financial problems and other difficulties faced by volunteer hospitals today and urged public support of present institutions on as full a scale as is possible as the only effective means of combating compulsory health insurance, which he said would "result in the spread of inefficient government bureaucracy."

Members of the hospital staff outlined in detail the reasons additional facilities were needed to provide adequate medical care for the community. Eight hundred people attended the meeting.

"Hotpoint Electric Equipment Repays Cost 3½ Times"

At left, Chief Chef Victor A. Ebding and assistant C. P. Fielder of Olive View Sanatorium.



Kitchen of Olive View Sanatorium showing modern Hotpoint equipment

Olive View Sanatorium Reports Amazing Results Of 11½ Years' Experience With Hotpoint Electric Equipment

IN 1936, Olive View Sanatorium (Los Angeles County, California) organized a committee to investigate the relative merits of various types of cooking equipment. They found that electric equipment offered these advantages: "Cooler, cleaner, requires less ventilation, easier to regulate, better control, safer, less meat-shrinkage, less pot cleaning, decreased fuel consumption, and minimum temperature fluctuation."

They also found that: *"Almost without exception, all chefs who have used both fuels are enthusiastically in favor of electricity."* A short time later, Olive View Sanatorium installed a Hotpoint Electric Kitchen—including 4 double-deck roasting ovens, 1 range, 6 griddles and 2 fry kettles.

Today—after 12 years—Olive View reports that their Hotpoint equipment is still in perfect condition! Non-electric equipment previously used had to be replaced every 7 years. Maintenance cost, which had averaged 10%, now averages only ½%.

Tests conducted in the Olive View kitchen prove Hotpoint Ovens have cut meat shrinkage 4% to 9%—a savings averaging about $95.00 a month. For the 11½ year period to date, this totals approximately $13,100—enough to repay the original cost of the equipment over 3½ times!

Olive View also reports that improved working conditions have increased both efficiency and morale of kitchen help. Their Hotpoint Electric Kitchen is a full 15° to 20° cooler than with previous equipment—and free of fumes and soot. Management states that kitchen walls had to be repainted only once in 9 years—compared to every 2 years with non-electric equipment.

Space occupied by compact Hotpoint equipment is considerably less than with former equipment—and the cost of operating this equipment, as proved by Olive View's own records, averages only about seven-tenths of one mill per meal per person! Olive View reports, "We feel that the installation of Hotpoint electric equipment was the best step that could have been taken to improve our facilities and working conditions."

1. Saves Food Flavors—Conserves maximum of natural juices, gives uniform results.

2. Cuts Food Costs—Reduces meat shrinkage, saves up to 60% on consumption of fat.

3. Cuts Labor Costs—Saves hours for cook, saves on cleaning and scouring, too.

4. Lasts Twice as Long—Independent study shows depreciation rate is cut in half.

5. Cuts Maintenance Costs—Analysis shows annual costs average 1-1½% of investment for Hotpoint, 2-5% for most flame types.

6. Saves Kitchen Space—Compact, easy to install in most efficient arrangement without regard to chimneys.

7. More Efficient—Midwestern university tests show that Hotpoint equipment is 2.68 times more efficient than flame type.

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NEWS...

Cancer, Tuberculosis Clinic Opened in Arkansas

PINE BLUFF, ARK.—A new tumor clinic has been opened for patients at Davis Hospital here, R. C. Warren, administrator of the hospital, has announced. The clinic will provide facilities for diagnosis and treatment of cancer, it was explained. In addition, facilities will be provided for a weekly clinical consultation in tuberculosis under the auspices of the Jefferson County Tuberculosis Association.

Occupying remodeled quarters in the hospital building, the clinic has a separate entrance for ambulatory patients and is fully equipped for cancer diagnosis, Mr. Warren said. The clinic is designed primarily to serve patients unable to pay hospital bills, and the hospital will receive no revenue except from the few patients who do not receive free care, it was explained.

"We are doing this because we want to render a service to the needy people of our community," Mr. Warren said. "Patients who are afflicted or suspected of being afflicted with cancer or tuberculosis may avail themselves of the free clinical treatment upon recommendation of their family physicians. The hospital makes no charge of any kind for the use of its facilities, including utilities. We regard it as a privilege to do our part in forwarding this great humanitarian effort to fight cancer and tuberculosis."

Funds for the treatment of indigent patients will be furnished by the Arkansas Cancer Control Commission, with assistance from the Arkansas Division of the American Cancer Society, the announcement said.

Value of Hospital Shops Discussed at Institutes

NEW YORK.—The importance of hospital gift and coffee shops was emphasized at a day's institute on the subject held October 21 at the Mountainside Hospital, Montclair, N.J., one of the first, if not the first, hospitals to inaugurate such a service. Invitations were sent to hospital volunteers engaged in such activities throughout the section, bringing a large attendance of those who would learn more concerning the details of successful shop operation.

Among those participating in the program were Mrs. Joseph T. Walmsley, manager of Hospitality Shop at Mountainside Hospital; Dr. Herbert M. Wortman, director, Mountainside Hospital; Raymond P. Sloan, editor, The MODERN HOSPITAL; Edith W. Johnson, chairman of volunteers, and Mrs. Olive M. Northwood, superintendent of nurses, Mountainside Hospital. Mrs. Wilfred J. Funk, chairman of Mountainside's Hospitality Shop, who first sponsored this undertaking many years ago, presided, with Mrs. Eva P. Bacon as coordinator.

Doctors Back Hospital Plan

CHICAGO.—A group of doctors and dentists in several suburbs northwest of the city has organized to support the proposal to build a hospital under Public Law 725 in the northwest suburban area, it was announced here last month. The group is organized as the Northwest Suburban Hospital Association. Dr. Martin P. Meisenheimer is president of the association, which includes thirty members from Northbrook, Glenview, Morton Grove, Mount Prospect, Prospect Heights, Arlington Heights and Wheeling.

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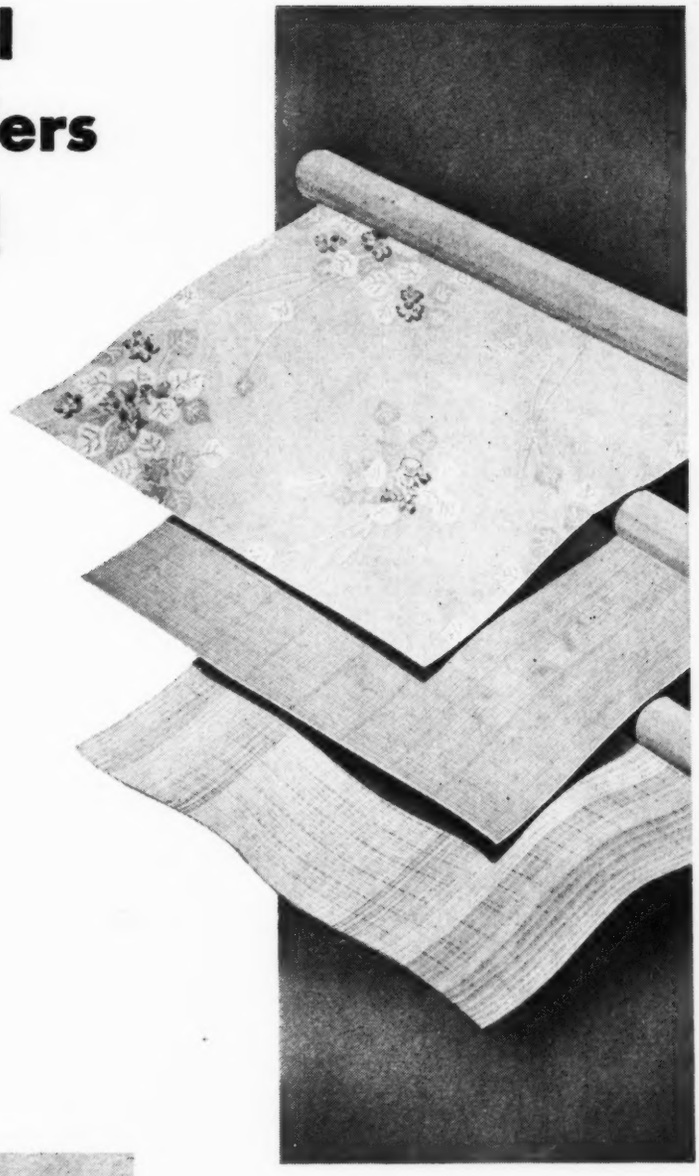

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FABRON's sturdy fabric backing prevents plaster cracks. Its plastic base actually toughens with age . . . resists scuffing . . . cannot scale or peel. Its sunfast, washable lacquer colors assure fresh, attractive rooms at all times. And it can be repaired easily and invisibly in the event of damage.

Despite its multiple advantages, FABRON is not "expensive". On the contrary, it is the *lowest in cost per year of service* — a fact which has been proved over and over in more than 1000 hospitals throughout the country.

Even the initial cost of FABRON is moderate — well within the average budget. Before you redecorate, be sure you have *all* the facts on FABRON.

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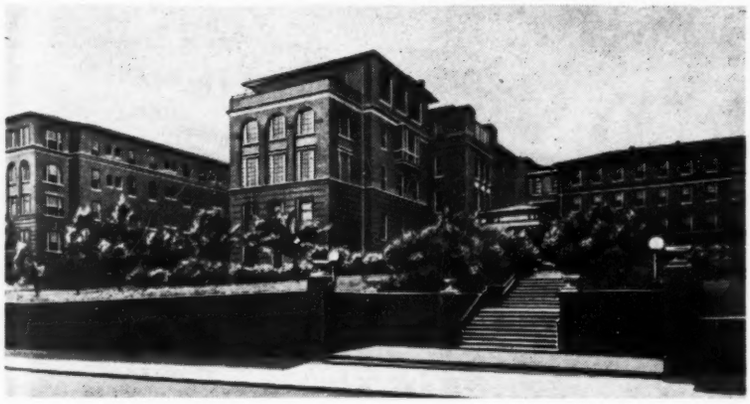

ELIZABETH STEEL MAGEE HOSPITAL, Pittsburgh, Pa. Miss Jessie J. Turnbull, *Supt.* This 309-bed hospital, which is a division of the Pittsburgh Medical Center, has used FABRON since 1943 in both the hospital itself and the nurses' home.

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NEWS...

Grant Provides Clinic Study of Alcoholism

NEW YORK.—A special clinic for the study of alcoholism will be set up under a grant provided by the New York State Department of Mental Hygiene, Dr. Frederick MacCurdy, department commissioner, announced last month. The grant will provide for a clinic to be established under the auspices of the University of Buffalo School of Medicine and two affiliated hospitals in Buffalo, Dr. MacCurdy explained.

The proposal provides for establishment of a clinical unit for short-term hospital care of selected patients and for diagnosis, ambulatory treatment and rehabilitation of a larger number of outpatients. In addition, funds will be provided for research in the psychiatric, physiologic and therapeutic aspects of the medical problem presented by alcoholics. It is expected that facilities in undergraduate and postgraduate medical education will also be provided, Dr. MacCurdy said. The program will be administered by the state health department with the assistance of an advisory board consisting of representatives of the state departments of mental hygiene, education, social welfare and correction.

Provident Hospital Seeks $200,000 to Meet Deficits

CHICAGO.—An immediate need for $200,000 to meet operating deficits must be met if the Provident Hospital here is to continue without vastly curtailing its services, H. Stanley Wanzer, president of the hospital board, said last month. Provident is the only hospital staffed entirely by Negroes certified for residency training in surgery, it was stated, and it is estimated that 80 per cent of the nation's Negro specialists have been trained here.

The 180 bed hospital serves an estimated four out of ten of Chicago's 100,000 Negro families, the majority of which are in the low income group, Mr. Wanzer stated. Clinic visits now total more than 5000 a month and the hospital's total charity load is second only in the Chicago area to Cook County Hospital, a 3000 bed tax-supported institution.

Illinois Hospital Group Calls Special Meeting in December

CHICAGO.—The Illinois Hospital Association will hold a special business meeting and midyear conference December 8 to 10 at Peoria, Leslie D. Reid, secretary, announced last month. This year's conference is being held in December instead of January in order to consider state legislation to be introduced in the General Assembly, which convenes in January.

Among the matters to be acted upon at business sessions of the conference will be proposed plans for the expansion of the state program and a proposed increase in state dues to provide funds for such expansion, it was explained. General sessions will include a seminar on nursing problems, primarily for hospital administrators, and a review of the Brown report on "Nursing for the Future."

Leo M. Lyons, first vice president of the Illinois Hospital Association, is chairman of the program committee. The committee on local arrangements is headed by Dr. C. S. Woods, superintendent of Methodist Hospital, Peoria.

NEWS...

Bulman Receives Award at A.D.A. Boston Meeting

(*Continued From Page* 138.)

throughout life in various subsequent human situations." Many of the practical difficulties with which the dietitian must deal can only be understood in terms of what food has come to mean to such persons.

In this connection, Isabelle M. Jordan, R.N., Children's Bureau, Washington, pointed out that problems in food intake and feeding practices arising from illnesses are minimal when the nurse understands the relationship between the child's nutritional needs and his development.

From still another point of view, that of the anthropologist, Dr. Margaret Mead pointed out later in the week that if dietitians are to make their full contribution to the health of the American people they must not only continue their work of developing desirable patterns of eating, but also cooperate with those systems of child rearing which will develop greater flexibility and capacity to make individual choices which are nutritionally sound. Our growing scientific insights should be completely integrated with our total cultural pattern.

Dr. Charles Glen King, scientific director of the Nutrition Foundation, concluded that recent basic advance made in the field of nutrition will result in practical gains in both health and economy to the degree that educators and manufacturers make use of the discoveries. Dr. E. M. Nelson, Food and Drug Administration, stated that regulations require that vitamin and mineral content of certain products be stated in terms of the minimum daily requirements of the nutrient that is supplied in the recommended daily intake of the food. Foods for the control of body weight, for infants, and foods having lowered allergenic properties are also required to carry labels giving the information specified in the regulations.

A practical demonstration of applied nutritional knowledge was demonstrated in the paper of John A. Fields, food service adviser, New York State Department of Mental Hygiene. He told how enriched bread is being used to provide needed food elements for patients in mental hospitals within the state. A survey in 1945 showed need to increase certain food elements, notably protein, vitamins and calcium. A breadmaking

formula was accordingly developed which contained nonfat dry milk solids and full-fat soya flour and which yields the required properties. Methods of fat rendering and refining have also been perfected, and its utilization has been explored and practiced with resulting economy.

A noted authority in the mental hospital field, Dr. Samuel W. Hamilton, a past president of the American Psychiatric Association, now superintendent of Essex County Hospital, Cedar Grove, N.J., said: "Mental hospitals need dietitians. Those of you who work in other situations might be aghast or unbelieving if told that there are institutions called hospitals that get along without dietitians. . . . Sometimes I have thought that our hospitals need some fighting dietitians, but . . . the one we would prefer . . . is one who by patient and courteous persistence will carry her point against all opposition."

Ways in which the dietitian achieves her objectives were demonstrated by more than sixty dietitian members of the association. Elma Benton, Veterans Administration Hospital, Tuscaloosa, Ala., asserted that with limited personnel it was necessary to develop in each employe a genuine interest in his work. She achieves this by encouraging reliability among them; by keeping them informed as to activities in the dietetic service; by letting them "know where they stand"; by using their ideas wherever possible; by promoting deserving employes; by treating all employes alike; by giving them the "story behind the story."

Doris Odle, Colorado General Hospital, Denver, said that in setting up the pay cafeteria the most important factors are careful budget planning, standardized recipes and portion control, good business methods of selling food and good overall management.

Mrs. Mary Harman Riste, Butterworth Hospital, Grand Rapids, Mich., noted for her high food standards, suggested that dietitians give their food a "new look." They should lead the way, she believed, in showing that the adequate planned diet represents not only a knowledge of sound nutrition but a familiarity with and a facility in preparing appetizing, attractive and good food as well. She emphasized color, line and balance in dishes and menus by means of slides.

A plea for close cooperation between the dietitian and the purchasing agent was sounded by Mildred Jones, Michigan State College, where dietitians meet regularly with the purchasing agent in the test kitchen to study samples of foods. Here, raw products, when prepared, are examined for quality, acceptability and cost. Dietitians indicate in writing the specific items they wish to use in their units. The purchasing agent keeps the dietitian informed on market conditions, prices, availability and quality through a weekly bulletin and at regular meetings. Recipes are also studied from the standpoint of standardized yields and costs, and cost of production and labor saving teachnics are also being studied.

Florence Quast, Syracuse University, suggested that when there is to be a new installation or a change in the existing setup, the dietitian should carefully analyze her needs and decide what kinds, size and make of equipment she wants. Then she should make a tentative floor plan. The next step is consultation with the architect for allot-

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ments of space and location of utilities.

A novel hospital service to hospitals without dietitians was described by Geraldine M. Piper, Oklahoma Department of Health. Her jeep serves as a kitchen pantry on wheels, with which she tours the state, loaded with recipe books, equipment manuals, posters, booklets and strip films. At first centering her consultant services on child care institutions, convalescent and maternity homes, and sanatoriums, she hopes to expand her work to all institutions in which meals are planned by persons having no specialized training in such planning or in quantity buying and preparation. Marian C. Jones, Indiana Board of Health, described a somewhat dissimilar type of service, in which she helps with licensing surveys made by hospitals and the Department of Public Welfare, reviews blueprints for new construction and consults on dietary problems.

Ray H. Coffman, training analyst, Office of Personnel, Veterans Administration, seemed to crystallize the thinking of the many speakers on the behavior of people as influenced by management when he said: "The successful supervisor at the lower organizational levels obtains production by stimulating group participation and by aiding his employes to satisfy their basic drives or needs for security, recognition and development through their work. He endeavors to share with his employes the making of decisions about planning, assignment and scheduling of work."

Dr. Thorne M. Carpenter discussed the highlights in the historical development of metabolism studies. Today such studies are more concerned with those factors which play individual rôles in the summation of total metabolism—we are more interested in the rôles of hormones, vitamins and minerals in the intermediary processes. Our knowledge of the ferments and enzymes which bring about the final oxidation involved in the supply and expenditure of energy materials is rapidly increasing. "Some well established concepts will have to be changed." The history of metabolism studies is still being made.

Dr. Charles E. Bills, Mead Johnson and Company, said that current interest in therapeutic low-sodium diets has stimulated investigation. Foods of animal origin are rich in sodium; grains, nuts and fruits in their natural state are nearly devoid of sodium—in them it is literally a trace element. Leaf, stalk and root vegetables are variable. In some towns the water supply may contribute sodium sufficient to make the low-sodium diet impossible.

Dr. James H. Currens, Massachusetts General Hospital, discussing the dietary treatment of hypertension, said that only 25 per cent of a group of outpatients were able to follow the popular "rice and fruit" diet exactly for any length of time. Some, hospitalized, did show a drop in blood pressure. One most important feature was the complete restriction of salt; if it was allowed, blood pressure rose immediately. "A great deal more must be known about the relation of diet to blood pressure before anything definite can be said."

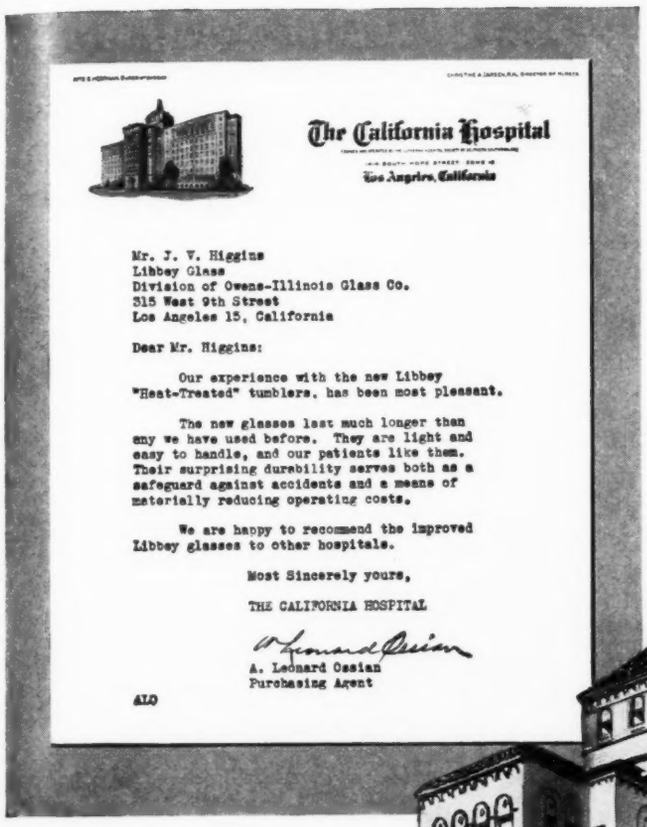
Dr. Elliott Joslin quoted a motto adopted from Hippocrates engraved on a building of Harvard Medical School:

"Life is short
And art long
Experiment perilous
Decision difficult."

Reviewing the developments of the

THE CALIFORNIA HOSPITAL REPORTS

LIBBEY HEAT-TREATED TUMBLERS . . .



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Los Angeles, California

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present treatment of diabetes and in the light of his own experience he is more than ever convinced that the precepts of Dr. Frederick M. Allen in rigorously controlling the disease are sound. Dr. Alexander Marble stated that recent work suggests the number of diabetics in the United States is nearer two million than the previous estimate of one million. Energetic and continuous treatment of diabetes is indicated to prevent both early and late complications, consisting chiefly of generalized vascular diseases. If diabetes is poorly controlled, after twenty years retinitis, coronary heart disease, peripheral vascular disease and chronic nephritis are "distressingly frequent."

Helen E. Walsh

At the close of the meeting Denver was announced as the 1949 convention city. Officers newly elected or appointed for 1948-49 are: president-elect, Helen E. Walsh, nutrition consultant, California Department of Health, San Francisco; vice president, Grace Bulman, Veterans Administration, Washington; secretary, Dr. Margaret Ohlson; food administration section chairman, Marion Floyd, Massachusetts General Hospital; community education section chairman, Adelia M. Beewkes, assistant professor of health education, University of Michigan; diet therapy section chairman, Marguerite L. Pettie, chief nutritionist, Medical College of Virginia. Mary W. Northrop, chief dietitian, King County Hospital System, Seattle, was named chairman of the council of the house of delegates.

New York City Reports Increase in New TB Cases

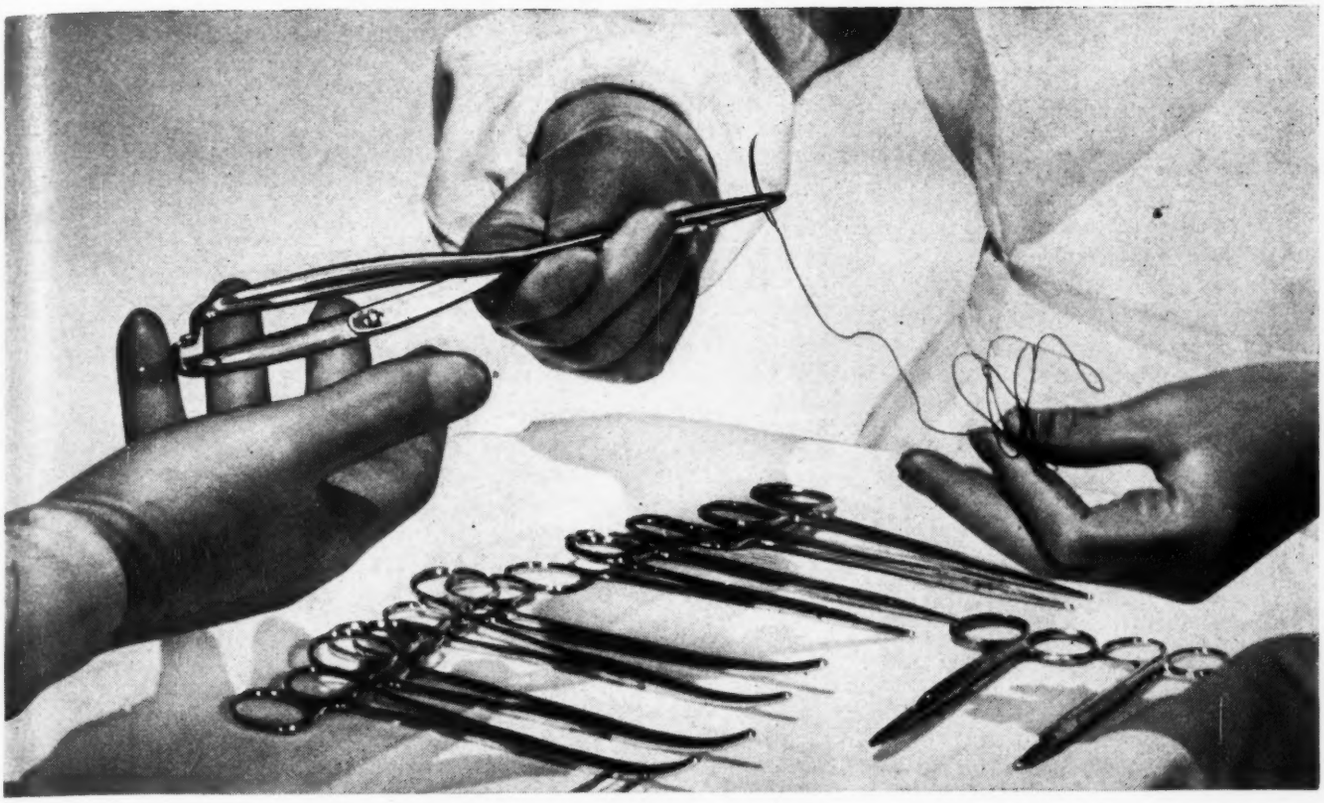
NEW YORK.—An increase in the number of new cases of tuberculosis in New York City was reported last month by the New York Tuberculosis and Health Association. The citywide jump for the first nine months of 1948 was 12 per cent, with Manhattan well in the lead with a 17 per cent increase. Increases were noted in every borough but the Bronx, with the highest rate of 9 per cent recorded for Manhattan.

Referring to the situation as serious, Dr. Edward P. Eglee, first vice president of the association, pointed out that the upswing in the incidence of tuberculosis foreshadows an even heavier strain on the city's already overloaded hospital facilities.

Dr. Herbert R. Edwards, executive director of the association and former chief of the tuberculosis control division of the city department of health, pointed out that there are undoubtedly many hundreds of unsuspected cases of tuberculosis in the city. X-ray surveys, he said, turn up many cases and of these about 80 per cent are listed as now or previously unreported.

Expands Fund Raising Program

BROOKLYN, N.Y.—St. John's Episcopal Hospital here has expanded its contract with a New York public relations firm to provide a full-time public relations and fund raising director, a full-time assistant and a part-time publicity representative, hospital officials announced last month.



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Sterile Pack canisters bring you the important savings realized from this modern package. Now you can use G.-I., Ob. & Gyn., Tonsil and Circumcision Sutures in Sterile Pack—same prices as Standard Tubes.

Ethicon's Atraloc swaged-needle sutures eliminate needle threading and give the surgeon optimum suturing facilities.

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ETHICON SUTURE LABORATORIES
DIVISION OF JOHNSON & JOHNSON, NEW BRUNSWICK, N. J.

ABOUT PEOPLE

(*Continued From Page 90.*)

pital, Plainfield, N.J. Miss Furnival completed her internship at Syracuse Memorial Hospital, Syracuse, N.Y. **Charles Turner,** another Northwestern graduate, is now serving as administrative intern at Syracuse Memorial.

Burton Sears has been appointed administrative assistant for the City-County Hospital System in Dallas, Tex. Mr. Sears completed his administrative internship at Baylor University Hospital last summer.

Maj. Roger A. Greene has been appointed business manager of the State Hospital for Crippled Children at Elizabethtown, Pa.

Robert A. Carney has been appointed to the position of assistant executive director of the Jewish Hospital in Cincinnati to replace **Rayner J. Kline,** who has resigned.

Haydn M. Deaner has accepted the position of assistant administrator at Truesdale Hospital, Fall River, Mass. He will serve in the capacity of acting administrator until the recovery and return of **Mrs. Delight S. Jones** who was seriously injured in an automobile accident. Mr. Deaner has just completed his administrative internship at George F. Geisinger Memorial Hospital, Danville, Pa.

Sister Mary Gerard has been appointed Superior of St. Catherine's Hospital, Omaha, Neb., succeeding **Sister Mary Theodore.** Sister Gerard was formerly Provincial of the Sisters of Mercy in Omaha.

Ross O. Urban has succeeded **Goldman Drury** as administrator of the City-County Hospital, Fort Worth, Tex. **W. Travis Wilson** took over the post of administrator of Memorial Hospital, Corpus Christi, made vacant by Mr. Urban's resignation.

Department Heads

Mrs. Alta M. Leonard, formerly director of nurses at Oak Park Hospital, Oak Park, Ill., is now serving in a similar capacity at Lincoln General Hospital, Lincoln, Neb.

Edith D. Payne has been named director of the Presbyterian Hospital School of Nursing and of Nursing Service, Pittsburgh, succeeding **Rachel A. Neill,** who has been acting director of the school for several months. Miss Payne resigned as director of the school of nursing of the Methodist Hospital in Philadelphia to accept her new position.

E. C. Bowerman has been named chief accountant at Bishop Clarkson Memorial Hospital, Omaha, Neb. Mr. Bowerman was with the Nebraska State Board of Control for ten years and the Hastings State Hospital, Hastings, Neb., three years.

Dr. Percy J. Carroll, retired brigadier-general of the army, has assumed the duties of dean of Creighton University School of Medicine, Omaha, Neb., and as chief of staff of Creighton Memorial, St. Joseph's Hospital. He succeeds **Dr. Charles M. Wilhelmj,** who assumed a new post as director of research at the university.

Miscellaneous

Dr. Thomas D. Dublin has been appointed executive director of the National Health Council. Dr. Dublin has served during the last six years as professor of preventive medicine and community health at Long Island College of Medicine, Brooklyn, N.Y. Before that he taught at the Johns Hopkins Medical School and Albany Medical College.

Dr. Frederic E. Elliott, director of

medical services since United Medical Service was founded in 1944, has been named a vice president of the organization, whose headquarters are in New York City. Dr. Elliott was formerly head of the x-ray department of Cumberland Hospital, Prospect Heights Hospital, and Bay Ridge Hospital, all in New York.

Gordon Davis has been appointed to direct public relations activities of the Cleveland Hospital Service Association. For the last two years he has been engaged in consultation work and at present is public relations consultant on the staff of James A. Hamilton and Associates.

Norman S. Goetz has been reelected president of the Hospital Council of Greater New York and **Mrs. Adrian Van Sinderen,** reelected treasurer. **John H. Hayes** was reelected vice president and two new vice presidents were elected, **Dr. George Baehr** and **Rev. John J. Curry.**

George A. Lindsley has recently been appointed hospital consultant in the division of hospital construction and services of the Illinois Department of Public Health. Mr. Lindsley was formerly administrator of the John and Mary E. Kirby Hospital, Monticello, Ill.

Perry Addleman, formerly director of the Chicago Hospital Council and, later, executive director of Chicago's Plan for Hospital Care, has been admitted to partnership in the firm of Booz, Allen and Hamilton, management consultants. Mr. Addleman, who has been associated with the management firm for the last eight years, will be located in the New York office, an announcement said.

Deaths

Dr. Edward Meadow, chief of the surgical staff of Biscayne Hospital, Miami, died October 10 of a heart attack. He was 39 years old.

Col. William Stoutenborough Terriberry, former assistant surgeon general and medical director of the United States Public Health Service, died October 13 in New London, Conn., at the age of 77.

Dr. Ernest C. White, medical director of Alexian Brothers Hospital, Chicago, died October 14. He was 69 years old. Dr. White had been director of the hospital for six years. Previously he was supervisor of U.S. Public Health clinics and hospitals in Illinois.

THE BOOKSHELF

NURSING FOR THE FUTURE. *A Report Prepared for the National Nursing Council. By Esther Lucile Brown, Ph.D. New York: Russell Sage Foundation.* 1948. $2.

In this stimulating report which has been evolved skillfully on the basis of an amazingly thorough and scholarly study, Esther Lucile Brown has given full and fair play to a multitude of points of view on a subject of vital importance to everyone everywhere. Incidentally, she has also proved the practicality and the value of a relatively new and promising method of achieving democratic thought and action. She has used the results of the thinking of probably more than 2000 people in developing a sound discussion which provides factual data covering the nursing field as it is today and which predicts on a seemingly sound and logical basis what it may be in the next half century in such a way that her conclusions, which are based on these facts and predictions, will inevitably form a basis for serious consideration in all planning for the future of nursing.

She may be very wise in all of the recommendations which she and her advisory committees make, or she may be proved by experience to be quite wrong in some, but she should receive full credit and gratitude for having brought the many factors involved together into a clear, concise presentation, arrayed them logically, and crystallized conclusions which may now be studied, discussed and experimented with, as must be done in any march toward progress. Her report takes the field a long way forward.

CONSTRUCTIVE SUGGESTIONS

Most interesting to observe is that not only does she give the answer as she sees it for the more distant future but she is also constructive in her suggestions for the transition period. All of those concerned with any form of nursing education at present will profit much from studying this document carefully, putting aside their natural defensiveness for what they have built up and trying to see if they cannot fit it into the pattern suggested as constructively as possible, for this pattern has been devised definitely with a view to what would seem best for society as a whole.

The National Nursing Council allowed Dr. Brown, a lay research worker, the maximum possible degree of freedom to develop her report on an examination of the question of who should organize, administer and finance professional schools of nursing, just as long as she viewed nursing service and nursing education in terms of what is best for society, not necessarily what is best for the profession.

In her effort to be as thorough as possible, she had arranged for her three regional conferences in which more than 1000 participated and provided through workshops a practical demonstration of how group thought and action could be achieved democratically. A special report, "A Thousand Think Together," prepared and distributed by the council covers this phase of the program in fine detail.

In analyzing the type of education which is requisite to prepare nurses to provide the services society needs, Dr.

Brown injects a new note in pointing out the similarity between engineering and nursing, stating that engineering, too, is an occupation that employs people of varying degrees of ability and training, that is, professional engineers, technicians and artisans, who might well be compared to professional nurses, practical nurses, and aides in range of function and qualifications. She advocates wide experimentation, pooling and exchange of ideas, critical evaluation of accomplishment, and then further experimentation on the basis of lessons learned. She insists, as an absolute antecedent to this, that there must be a conviction that new patterns of nursing service must be evolved in the interest of quality and quantity.

She states definitely with regard to the training of practical nurses that no successful program can be evolved until the public, educators, health agencies, including the medical profession and hospital administrators, nursing associations and state boards of control are prepared to show an active interest in practical nursing far beyond any interest yet shown. In her examination of the field she found, evidently, extremely little real interest in the training of practical nurses even though it seemed to her almost equally important with the training of the graduate nurse.

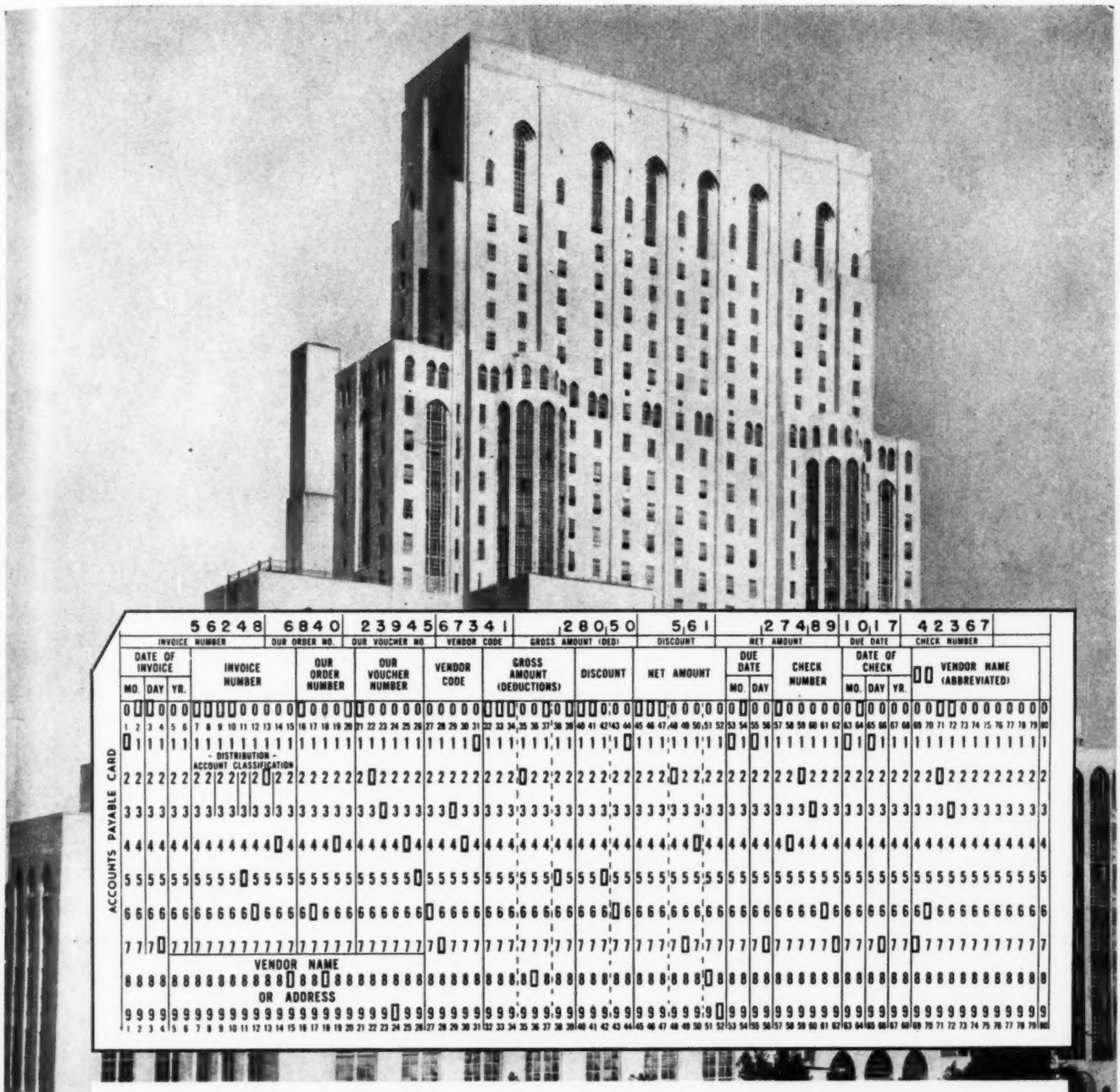
Her discussion of the education for the graduate bedside nurse is perhaps the most interesting part of the whole report for many who are concerned now with schools that do not offer degrees. Her final conclusion is that there will in the future be the professional nurse who is trained in a university or college degree program, and the practical nurse, and that she is not sure that there will be a place left for the graduate bedside nurse as she now appears as the general and private duty nurse of today.

She quotes the findings of the U.S.P.H.S. that only 13 per cent of the 1125 schools of nursing which participated in the cadet nurse corps program received a rating of good or excellent. She recommends that nursing make an official examination of every school and set up an accreditation system and rally support for accredited schools, and that this be done with the public assuming responsibility for a substantial part of the financial burden.

MUST CONTINUE TO WORK

It is her conviction that during the transition period while the new pattern is being worked out, the relatively good hospital school is not absolved from continuing its work. It must offer its students the best possible preparation for skilled bedside nursing and give them a familiarity with the general problems of a complete health service. She recommends a flexibility in outlook on the part of those responsible for such schools that will lead them to improve their positions and may bring them finally within a university professional curriculum, should that become desirable. She recommends that the relatively good schools make concerted effort through various types of experimentation to increase their vitality and social usefulness and to point the way to a solution for themselves. Especially recommended as transitional steps are the creation of central schools of nursing and the utilization of the teaching resources of junior colleges.

As to the distinguished schools that now operate programs which do not lead to a degree, she recommends that provision be made within universities for their continuing their contributions undiminished, and that they be given wholehearted assistance in reorganizing themselves into degree programs. Support toward this end should be given



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by all concerned but especially by the laity influential in effecting policy and molding public opinion.

For the hospitals that provide only specialized medical services, her feeling is that their best contribution lies in providing affiliations for other schools rather than in operating small schools of their own.

When it comes to the education for the professional nurse, almost without a dissenting voice, she says, everyone agrees that it is the responsibility of the institution of higher learning. She has come to the conclusion that all schools created in the future should be within such institutions and should be made autonomous and be vested with the same status as the other professional schools. She has excellent suggestions for facilities, faculty and organizational structure.

It is Miss Brown's feeling that gifts and subsidy must be raised to support these schools. She cites Miss Petry's contention that in no other profession is so large a share of the cost of education borne by the student either in the way of tuition and fees or in service, and that to make the profession attractive, this must be changed. Such support, however, should be given purely on the basis of the educational standards maintained by individual schools.

She ends up with a note of advice that positive steps be taken by the profession to create an atmosphere conducive to attracting carefully selected representatives of a true cross section of the population to nursing.

Two points stand out as particularly important in reviewing this excellent treatise, which in itself merits several readings because it is so comprehensive and thought-provoking. One is the objective decided upon as best in teaching the student nurse, and the other is the conclusion as to who is to do the real planning for the future of the nursing profession.

She states that teaching must be in line with the best contemporary principles of education. She advocates better integration of preclinical and clinical teaching; permeation of the entire curriculum with preventive as well as curative, and mental as well as physical, aspects of nursing; more emphasis on the care of the ill in the home and in emergency, and greater attention to the students' physical emotional intellectual and social development. In other words, larger consideration must be given, she feels, to the function of the nurse as a citizen and as a member of the health services if she is to fit into the nursing needs of society in the future.

TO MAINTAIN PROFESSIONAL STATUS

She recommends that appropriate nursing bodies initiate planning for the distribution of the kind of schools designed to meet state needs and that representatives of education, the health services, and those in a position to influence public opinion give general assistance in every way, including maximum financial support, in the undertaking. This is in accord with the thinking of those who want to see nursing maintain its professional status, which inherently means that it must decide its own content and policies, but who know that the problem belongs to the community as a whole and so must be supported in every way by far more than just the nursing group itself.

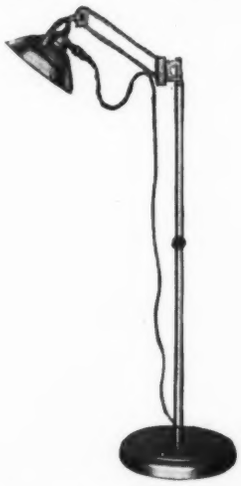
The report undoubtedly should be required reading for all who are in any way concerned with nursing in the future. It will do much toward finding more rapidly the correct solution of one of modern society's most vital problems.
—NELLIE GORGAS.

What's New FOR HOSPITALS

NOVEMBER 1948 Edited by BESSIE COVERT

For further information on new products see coupon on page 256

Explosion-Proof Lights



The new series of Castle Safelights has been approved by the Underwriters' Laboratories for use in Class I, Group C, Hazardous Locations. This covers use in operating rooms where inflammable anesthetic gases are handled. The new lights utilize the same explosion-proof lighting unit on four different styles of mountings, thus providing every type of light that might be required. Mountings include ceiling, wall and portable with the newly developed pantograph arm and another portable light with conventional counterbalanced arm which raises, lowers and tilts to any needed angle at any height.

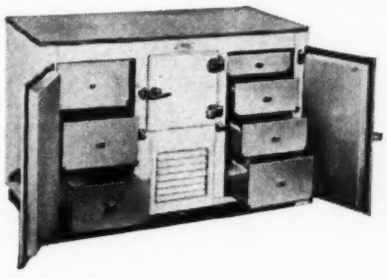
The Castle No. 52 Safelight, illustrated, is a portable spotlight designed for use in a surgery equipped with an overhead light, to provide illumination of areas such as horizontal cavities. It is vertically adjustable to above head level or to below level of the operating table. The adjusting handle can be removed for autoclaving, thus permitting sterile personnel to adjust the lamp during the operation if necessary.

The new Safelights are prefocused, with an unusually long depth of focus, uniform throughout in intensity; they have a new style of reflector which gives excellent shadow reduction; a special filter eliminates the excessively yellow light rays, and the new pantograph arm permits easy adjustment of the lamphead through a vertical range of approximately 25 inches with no dependence on friction and no manual locks or clamps. **Wilmot Castle Co., Dept. MH, Rochester 7, N. Y. (Key No. 240)**

Biological Refrigerator

The new Deluxe Model 500 biological refrigerator has been designed specifically for the storage of drugs and serums without loss of potency. The unit will maintain a constant 38 degree F. temperature with outside temperatures reaching as high as 110 degrees. The cold air is circulated by a blower which equalizes and maintains the desired temperature throughout the unit. The refrigeration unit is hermetically sealed and requires no lubrication or service.

The refrigerator has 7 drawers made of expanded metal sides which permit the cold air to circulate freely. They are built so that they can be pulled to full length when fully loaded and are arranged with storage compartments in enough sizes to permit classification of all items within easy reach. An electrically operated moisture eliminator keeps the contents in proper condition.



The refrigerator is built of white enameled heavy gauge steel, insulated with fiber glass and has a utility top which can be used as counter or work table space. It is 36 inches high. **The Dillon-Lilly Co., Inc., 515 New York Bldg., St. Paul 1, Minn. (Key No. 241)**

Food Warmer

Model SSY-110, known as the Scotty Mate, is a new addition to the line of stainless steel portable food warmers developed by Seco. The entire line is again available after an absence of nearly five years. Adaptable as an individual unit, the Scotty Mate can also be used in banks of two or more or can be added to an already working bank of matched electrical counter kitchen appliances.

The Scotty, as all items in the line, is fabricated of stainless steel and has the new Current Miser operating efficiency, touch dial thermostatic 5 way temperature control and can be plugged in anywhere. Most models in the line have 12 by 20 inch top openings and feature 30 different interchangeable pan top combinations. **Seco Co., Inc., Dept. MH, 5206 S. 38th St., St. Louis 16, Mo. (Key No. 242)**

Wall-Saving Easy Chair

The attractive, modern easy chair developed by Hospital Furniture, Inc., has been designed to provide relaxed sitting comfort for patients of any size or age and at the same time to prevent scraping or marring of walls. The shape of the chair frame is such that when the chair is pushed against the wall, the top will not touch it, thus avoiding any possibility of damage to wall finish.

The chair has spring under-construction and is sturdily built on functional lines to give long service. The cushions are removable and reversible with extra cushions available so that the chair can continue in use even if an accident soils the cushions. Made with fine coil springs, the cushions are covered with an imported wool pile fabric which is latex backed, thus permitting easy foam scrubbing and making the cushions mothproof. Slip covers are unnecessary since the cushions are readily cleaned and they are available in bright, attractive colors including golden copper, sea green and lipstick red. Wood finishes in the chair, the footstool and the table illustrated are frosted walnut, mahogany

or champagne. **Hospital Furniture, Inc., Dept. MH, 936 N. Michigan Ave., Chicago 11. (Key No. 243)**

Isolation Bassinet

The Simmons Isolation Bassinet consists of a bassinet stand with Simfast finish which is unaffected by heat or cold and retains its attractive appearance even after repeated cleansings, the transparent Simmons plastic bassinet basket and a detachable bassinet cabinet which is easily and securely attached to the bassinet stand.

The bassinet provides facilities for individual care of the infant either in the nursery or as an isolation unit. The detachable cabinet has no doors or drawers, thus simplifying nursing care. Of all steel welded construction with rounded corners for ease of cleaning, the cabinet is finished in Simfast white, ivory or aluminum. The bassinet is available with or without the cabinet. **Simmons Company, Dept. MH, Merchandise Mart, Chicago 54. (Key No. 244)**

Aluminum Curtain Track

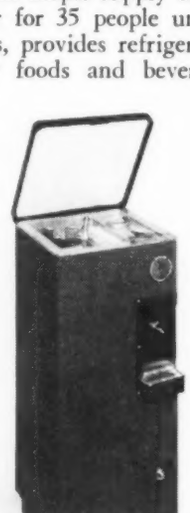
Cubicle curtains, window curtains and draperies and hangings of any type can be easily hung with Jiffy Join Slider Tape and track. The new aluminum track has been especially designed for hospital cubicle curtains and provides a completely noiseless, foolproof unit. Jiffy Join Slider Tape, permanently sewed to the curtains, is not damaged by laundering. The slider tape is readily inserted into the new aluminum track which is light in weight and takes a minimum of space. Curtains can be easily pulled in any direction on the aluminum track and are carried around curves or corners without interference. **Jiffy Join, Inc., Dept. MH, 153 W. 23rd St., New York 11. (Key No. 245)**

"Coronized" Fiberglas

Curtain and drapery material of "Coronized" Fiberglas is now available to reduce fire hazard where it is part of the decorating scheme. The Coronizing process provides fabrics woven of Fiberglas yarns with a permanent soft feel and good draping characteristics. In addition to its fireproof qualities, the fabric is mildewproof, not affected by moths, silver fish and other fiber eating insects, is wrinkleproof and water-repellent and has stood up under hot, damp weather tests. It can be hand or machine sewed, hand or machine washed or dry cleaned by conventional methods. Curtains or draperies of the material dry quickly and do not require ironing or stretching. **Owens-Corning Fiberglas Corp., Dept. MH, Nicholas Bldg., Toledo 1, Ohio. (Key No. 246)**

Three-In-One Cooler

The new Sunroc Model 26 cooler is a combination unit which should serve a real need in floor kitchens, utility rooms and other areas where small quantities of refrigerated supplies are needed. The unit has an ample supply of cool drinking water for 35 people under average conditions, provides refrigerated storage space for foods and beverages which



is reached from the top, thus eliminating need for stooping, and has an ice cube compartment with three trays.

The compact unit is attractively designed and housed in a heavy gauge all steel cabinet finished in Sunglow Metal. The compartments for food and water are of stainless steel and the mechanism is hermetically sealed and self-lubricating. **Sunroc Refrigeration Co., Dept. MH, Glen Riddle, Pa. (Key No. 247)**

Fire Retarding Window Shades

The new Diana Fyrban window shades are made of Vinylite plastic and have proved in tests to be undamaged when subjected to flame. In addition they are sunproof and waterproof, can be washed without damage, and should give long service with simplified maintenance. **Stewart Hartshorn Co., Dept. MH, 250 Fifth Ave., New York 1. (Key No. 248)**

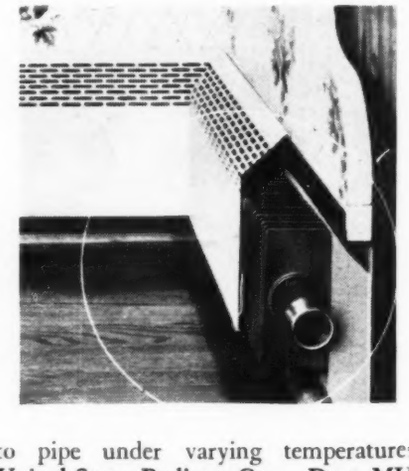
Psychiatric Package Window

The new Fenestra Psychiatric Package Window is the result of years of experience and research by psychiatrists, administrators, architects and the manufacturer. It is designed to serve as a complete window unit especially developed to meet the needs in institutions for mental patients. The casing is rebated to receive safety detention type screens, protective screens, insect screens and guards as desired. There are no locks or bars to suggest detention, ledges are eliminated because of flush installations, the entire unit is noncombustible and the inside screens protect the patient and prevent material being thrown from windows.

The window unit is precision built of steel and is equipped with a steel casing and a twin-screw sill adjuster. Two ventilators, which swing out at the bottom to deflect drafts upward and shed rain to the outside, alternate with two fixed lights. The design permits easy washing of both the inside and the outside of the windows from within the room. **Detroit Steel Products Co., Dept. MH, 2250 E. Grand Blvd., Detroit 11, Mich. (Key No. 249)**

Baseboard Convector

The U. S. Fin-Ray Baseboard Convector is a new fin-type steel radiator enclosed with a grilled steel covering plate which is installed around the base of the walls of a room in place of the usual baseboard. The new unit is designed to distribute heat evenly over the wall and window areas, thus providing even temperatures without draft. It can be installed in new or remodeled buildings and the front cover of the convector, which can be easily removed for cleaning, can be finished to harmonize with any general color scheme. Made of high quality steel pipe and rugged, tempered steel fins, the construction of the unit ensures constant rigidity of fin



to pipe under varying temperatures. **United States Radiator Corp., Dept. MH, Detroit 31, Mich. (Key No. 250)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 256

Pharmaceuticals

Sodium Ascorbate

Sodium Ascorbate Solution has been developed for intramuscular and intravenous injection in the treatment of scurvy, gingivitis and other disorders partly or wholly due to vitamin C deficiency. It is supplied in 2 cc. and 5 cc. ampules. **Bristol Laboratories, Inc., Dept. MH, Syracuse 1, N. Y. (Key No. 251)**

Dienestrol Suspension White's

Dienestrol Suspension White's is a sterile solution containing microcrystals of Dienestrol in normal saline with chlorobutanol as bacteriostatic agent. It is designed for intramuscular injection in the treatment of menopausal symptoms and for inhibition of breast engorgement or suppression of lactation. It is available in 10 cc. multiple dose, rubber-stoppered vials. **White Laboratories, Inc., Dept. MH, 113 N. 13th St., Newark 7, N. J. (Key No. 252)**

Priscol

Priscol is an adrenolytic and sympatholytic agent designed to improve circulation in patients with intermittent claudication, Buerger's disease and similar conditions. It is a colorless, crystalline, water-soluble compound for oral or parenteral administration which causes vasodilatation and relieves angiospasm. It is available in tablets or multiple-dose vials. **Ciba Pharmaceutical Products, Inc., Dept. MH, Summit, N. J. (Key No. 253)**

Natestrin Tablets

Natestrin Tablets, coated red, contain naturally occurring equine estrogens and are indicated primarily for administration in the control of symptoms of the menopause. They are supplied in bottles of 100, 500 and 1000. **The Upjohn Company, Dept. MH, Kalamazoo 99, Mich. (Key No. 254)**

Cresatin Ointment

Cresatin Ointment is an efficacious penetrating volatile fungicide for treatment of mycotic skin infections. It contains 80 per cent metacresylacetate in a specially prepared ethyl cellulose base. Relatively nontoxic, the product posesses analgesic and antiseptic properties and exerts a mild keratolytic and strong fungicidal action. It is supplied in ¼ ounce collapsible tubes. **Sharp & Dohme Inc., Dept. MH, 640 N. Broad St., Philadelphia 30, Pa. (Key No. 255)**

Product Literature

• **"Antihistamine Therapy"** is discussed in a booklet issued by Hoffmann-La Roche Inc., Nutley 10, N. J. Historical information, illustrations of histamine release mechanism in allergy and concept of various methods used to combat histamine, laboratory and clinical data and other information on Thephorin are some of the subjects covered. **(Key No. 256)**

• The American Gas Association, 420 Lexington Ave., New York 17, has recently issued a most impressive book on **"Commercial Kitchens."** A reference book and guide for those concerned with volume cooking, the book has 242 pages and is board bound. In addition to information on the gas industry and the market for gas service, the book has chapters on commercial cooking, planning a new kitchen, planning modernization and alterations, layouts for kitchens, fuels other than gas and other helpful data. The book sells for $5 per copy and is completely indexed. **(Key No. 257)**

• **"Streptomycin in the Treatment of Tuberculosis"** is the title of a new 28 page book recently issued by Abbott Laboratories, North Chicago, Ill. Prepared for the medical staff, the booklet represents the present consensus of the various cooperating groups most active in the testing of Streptomycin for tuberculosis. **(Key No. 258)**

• **"Vitallium Surgical Appliances"** is the title of a comprehensive revised catalog issued by Austenal Laboratories, Inc., 224 E. 39th St., New York 16. The complete line of Vitallium surgical appliances for internal fracture fixation, arthroplasty, bone and cartilage replacement, internal duct repair and blood vessel anastomosis is listed with full descriptive information and helpful details. Orthopedic appliances are grouped as are general surgical appliances and other specialized items. The catalog contains a helpful reference bibliography on the various appliances and is fully indexed. **(Key No. 259)**

• A new quarterly publication, entitled **"Scientific Apparatus and Methods,"** has been issued by E. H. Sargent & Co., 155 E. Superior St., Chicago 11. The publishers state their threefold purpose as: to present original articles of interest to the chemical profession; to present new and interesting laboratory apparatus, and to provide a supplement to the company catalog which will keep readers abreast of the trend in equipment changes. The first issue is attractively laid out and printed, has 32 pages plus cover, and should prove of especial interest to those in the laboratory. **(Key No. 260)**

• **Catalog 32, "Puritan Gas Therapy Equipment,"** has recently been released by Puritan Compressed Gas Corporation, 2012 Grand Ave., Kansas City 8, Mo. This attractively laid out folder, printed in color and black and white, gives detailed information, with illustrations, on equipment and accessories for gas therapy, with prices on all items. **(Key No. 261)**

• An attractively laid out and printed booklet has been issued by David E. Kennedy, Inc., 72 Second Ave., Brooklyn 15, N. Y., entitled **"About Cork."** Sub-titled, "An Architect's Handbook on Kencork Floors and Walls," the book carries information on the history of cork, physical characteristics of cork, why cork floors and walls, floor installation, wall installation, floor maintenance and protection, architects' specifications and other helpful material. Illustrations of cork installations add to the interest. **(Key No. 262)**

Book Announcements

The Macmillan Company, 60 Fifth Ave., New York 11. Leigh and Belton, "Pediatric Anesthesia," 240 pp., $5.50. **(Key No. 263)**

The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Mo. Gradwohl, "Clinical Laboratory Methods and Diagnosis," 4th ed., 3 vol., 3264 pp., $40. Ilgenfritz, "Preoperative and Postoperative Care of Surgical Patients," 2nd ed., 836 pp., $10. Pottenger, "Tuberculosis," 597 pp., $12. Price, "A Handbook of Charting for Student Nurses," 3rd ed., 386 pp., $3.75. Zoehout, "Introduction to Human Physiology," 424 pp., $4. **(Key No. 264)**

G. P. Putnam's Sons, 2 W. 45th St., New York 19. Darby, "Laboratory Chemistry," manual of laboratory exercises arranged in 12 two hour periods, $2.20. Hunt, "Anesthesia, Principles and Practice," a presentation for the nursing profession, $2.60. Johnson, "A Laboratory Manual in Cookery," laboratory manual in cooking and diet therapy for student nurses, $2.50. **(Key No. 265)**

Russell Sage Foundation, 130 E. 22nd St., New York 10. Brown, "Nursing for the Future," 198 pp., $2. **(Key No. 266)**

W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa. A.M.A. Intern's Manual, Prepared by Councils and Bureaus of the American Medical Assn., 201 pp., $2.25. Turner, "General Endocrinology," 604 pp., $6.75. **(Key No. 267)**

The Williams & Wilkins Co., Mt. Royal & Guilford Aves., Baltimore 2, Md. Brailsford, "Radiology of Bones and Joints," 4th ed., $15. Feldman, "Clinical Roentgenology of the Digestive

Address manufacturers for further information and prices—or use Readers' Service blank on page 256

Tract," 3rd ed., $8. Geckeler, "Plaster of Paris Technic," 2nd ed., $3. Kemp, "Elementary Anesthesia," $5. Licht, "Occupational Therapy Source Books," $1. Minnitt and Gillies, "Textbook of Anesthetics," 7th ed., $8. **(Key No. 268)**

Suppliers' Plant News

Angelica Jacket Co., 1501 Locust St., St. Louis 3, Mo., manufacturer of uniforms, announces the opening of a new store and sales room at 130 N. E. Second Ave., Miami, Fla. The new store has been opened to give customers in that territory better service. **(Key No. 269)**

Bell & Howell Co., Chicago, announces removal of its Microfilm Division from 221 N. LaSalle St. to **1801 Larchmont, Chicago 13. (Key No. 270)**

Clark Linen & Equipment Co., 303 W. Monroe St., Chicago 6, announces the establishment of a special hospital equipment and supply division to be known as **The Clark Company.** The new department will be directed by **William R. Rado,** who has joined the company as sales manager. **(Key No. 271)**

Thomas A. Edison, Inc., Medical Gas Div., announces removal of the plant from Bloomfield, N. J., to **Stuyvesant Falls, N. Y.** The new mail address is P.O. Box 16. **(Key No. 272)**

Harris & Wellman, Inc., dealer in hospital supplies, announces removal of its offices from 629 W. Washington Blvd., to **1400 W. Washington Blvd., Chicago 7. (Key No. 273)**

Hewitt Restfoam Div., Hewitt-Robins Incorporated, Buffalo 5, N. Y., manufacturer of latex foam mattresses, announces the opening of a new $850,000 addition to the Restfoam plant to make mattress topper pads and Restfoam cushioning. **(Key No. 274)**

Hotpoint Inc., 5600 W. Taylor St., Chicago 44, manufacturer of electric equipment, announces opening of its new electric range plant occupying one million square feet of manufacturing space and incorporating revolutionary mass production technics. **(Key No. 275)**

The National Drug Co., 4663 Stenton Ave., Philadelphia 44, Pa., manufacturer of pharmaceuticals, announces the opening of a new Research Laboratory at Haines & MacCallum Streets in Germantown. Equipped with the most modern scientific equipment and apparatus, the new laboratory is prepared to carry out any phase of medical research. **(Key No. 276)**

Pfaelzer Brothers Inc., Union Stock Yards, Chicago 9, purveyor of meats to institutions, announces the acquisition of the plant and facilities of the American Meat Co., 416 E. 3rd St., Kansas City, Mo. The plant will be operated from Kansas City as the American Meat Corporation and the company will operate independently under the new ownership. **(Key No. 277)**

Edward Weck & Company, Inc., 135 Johnson St., Brooklyn 1, N. Y., manufacturer of surgical instruments, makes the following announcement: "Since Dr. Strauch's article appeared in the American Journal of Surgery, August 1948, and since our advertising (of the Strauch Screw-pin) in that magazine and others, we have learned that the steel we planned to use for these Strauch Screw-pins was possibly not the best material to be had. Research and medical authorities have recently developed a new steel which, they claim, has properties not obtainable before. The inertness of this steel when contained in the body makes a superior instrument. Because of this new material, we are holding up all orders for these screw-pins and will contact you again as soon as we are satisfied that we are using the best possible material." **(Key No. 278)**

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it.

Bessie Covert,
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